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ABSTRACT

This report contains a number of the papers submitted to the President's Commission on Law Enforcement and Administration of Justice, by outside consultants. Chapter Eight of that commission's report, "The Challenge of Crime in a Free Society," is reprinted at the beginning of this report, with the addition of annotations to indicate source materials considered. But this volume does not in any sense embody a comprehensive treatment of the complex and important problems of drug abuse. Limitation of resources has led this commission to limit the scope and depth of its work in this area. Among the topics discussed in this report are: (1) the drugs and their reputation, (2) enforcement, (3) drug abuse and crime, (4) penalties, (5) marihuana, (6) treatment, (7) civil commitment, (8) medical practice and addiction, and (9) education. Six appendix sections are presented covering such topics as dangerous drugs, narcotics, drug legislation, treatment of drug addiction, and civil commitment of narcotic addicts. (Author/BW)

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TASK FORCE REPORT:

NARCOTICS AND DRUG ABUSE

ANNOTATIONS AND CONSULTANTS' PAPERS

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Task Force on Narcotics and Drug Abuse
THE PRESIDENT'S COMMISSION ON LAW ENFORCEMENT AND ADMINISTRATION OF JUSTICE

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Publications of the President's Commission on Law Enforcement and Administration of Justice

Commission Report: The Challenge of Crime in a Free Society

Supporting Materials

- Task Force Report: The Police
- Task Force Report: The Courts
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- Task Force Report: Assessment of Crime
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NARCOTICS AND DRUG ABUSE

ANNOTATIONS
AND
CONSULTANTS' PAPERS

Task Force on Narcotics and Drug Abuse

THE PRESIDENT'S COMMISSION ON LAW ENFORCEMENT AND ADMINISTRATION OF JUSTICE

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Copies of other task force reports and other supporting materials can also be purchased.

FOREWORD

In February of this year the President's Commission on Law Enforcement and Administration of Justice issued its general report: "The Challenge of Crime in a Free Society." Chapter 8 of that report made findings and recommendations relating to narcotics and drug abuse. That chapter is reprinted at the beginning of this volume, with the addition of annotations to indicate source materials considered. In addition, this volume contains a number of the papers submitted to the Commission by outside consultants. Some material from these papers was used as background documentation in the preparation of the chapter, and they are believed to be of interest and value as source material. But this volume does not in any sense embody a comprehensive treatment of the complex and important problems of drug abuse. Limitations on our resources and the fact that another presidential commission with specific responsibility for these problems had recently issued its report led the Commission to limit the scope and depth of its work in this area.

A panel of Commission members had special responsibility for this area. Many members of the Commission staff participated in the work on this subject, and Anthony Lapham and Bruce J. Terris of the staff devoted their primary attention to it. The inclusion of consultants' papers does not indicate endorsement by the panel of Commission members or by the staff.

As noted in the foreword to the general report, the Commission's work was a joint undertaking, involving the collaboration of Federal, State, local, and private agencies and groups, hundreds of expert consultants and advisers, and the Commission's own staff. The Commission is deeply grateful for the talent and dedication of its staff and for the unstinting assistance and advice of consultants, advisers, and collaborating agencies whose efforts are reflected in this volume.

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*This section of the report is an annotated version of the chapter on narcotics and drug abuse appearing in the Commission's general report, "The Challenge of Crime in a Free Society."

TABLE OF RECOMMENDATIONS

This Table of Recommendations is reprinted from the General Report of the Commission, "The Challenge of Crime in a Free Society."

Enforcement

Increase staffs of Bureaus of Customs and Narcotics 9
Adopt State drug abuse control legislation 9
Amend Federal drug abuse control law to strengthen recordkeeping provisions 10
Revise sentencing laws to give adequate flexibility 12

Research and Education

Undertake research with respect to regulation of drugs 6
Conduct research at National Institute of Mental Health (NIMH) on marihuana use 14
Develop educational materials at NIMH 20

Narcotics and Drug Abuse

IN 1962 A White House Conference on Narcotic and Drug Abuse was convened in recognition of the fact that drug traffic and abuse were growing and critical national concerns. Large quantities of drugs were moving in illicit traffic despite the best efforts of law enforcement agencies. Addiction to the familiar opiates, especially in big-city ghettos, was widespread. New stimulant, depressant, and hallucinogenic drugs, many of them under loose legal controls, were coming into wide misuse, often by students. The informed public was becoming increasingly aware of the social and economic damage of illicit drug taking.

Organized criminals engaged in drug traffic were making high profits. Drug addicts, to support their habits, were stealing millions of dollars worth of property every year and contributing to the public's fear of robbery and burglary. The police, the courts, the jails and prisons, and social-service agencies of all kinds were devoting great amounts of time, money and manpower to attempts to control drug abuse. Worst of all, thousands of human lives were being wasted.

Some methods of medical treatment, at least for opiate-dependent persons, were being tried, but the results were generally impermanent; relapse was more frequent than cure. The established cycle for such persons was arrest, confinement with or without treatment, release, and then arrest again. And the cause of all of this, the drug-prone personality and the drug-taking urge, lay hidden somewhere in the conditions of modern urban life and in the complexities of mental disorder.

Responsibility for the drug abuse problem was not at all clear. Was it a Federal or a State matter? Was it a police problem or a medical one? If, as seemed evident, it was a combination of all of these, which agencies or people should be doing what? The Conference did not answer these questions, but it did bring to them a sense of national importance and commitment.[1]

The President's Advisory Commission on Narcotic and Drug Abuse was created in 1963 to translate this commitment into a program of action. The Commission's final report, issued in November of that year, set forth a strategy designed to improve the control of drug traffic and the treatment of drug users.[2] The 25 recommendations of that report have been the basis for most of the subsequent Federal activity in this field. Many of them, notably those pertaining to civil commitment for narcotic addicts and the need for Federal controls on the distribution of nonnarcotic drugs,[3] have been or are in the process of being implemented.

This Commission has not and could not have undertaken to duplicate the comprehensive study and report on drug abuse so recently completed by another Presidential Commission. Yet any study of law enforcement and the administration of criminal justice must of necessity include some reference to drug abuse and its associated problems. In the course of the discussion in this chapter, recommendations are made where they seem clearly advisable. In many instances these recommendations parallel ones made by the 1963 Commission.

There have been major innovations in legal procedures and medical techniques during the last few years. There are new Federal and State laws and programs designed to provide treatment both for narcotic addicts charged with or convicted of crime, and for those who come to the attention of public authorities without criminal charge. These laws and programs signify that the Nation's approach to narcotic addiction has changed fundamentally. They are a creative effort to treat the person who is dependent on drugs.

Careful implementation, evaluation, and coordination of the new programs, some of which are not yet in operation will be absolutely essential. These are among today's first needs. New ideas are only a first step. Unless the programs they lead to are provided with sufficient money and manpower and are competently administered, no improvement in drug abuse problems can be expected.

THE DRUGS AND THEIR REGULATION

The drugs liable to abuse are usually put into the two classifications of "narcotics" and "dangerous drugs," and the people who abuse them are usually called "addicts" and "users." The terms have been used carelessly and have gathered around them many subjective associations. Some precision is necessary if they are to be used as instruments of analysis.

ADDICTION

There is no settled definition of addiction. Sociologists speak of "assimilation into a special life style of drug taking." Doctors speak of "physical dependence," an alteration in the central nervous system that results in painful sickness when use of the drug is abruptly discontinued; of "psychological or psychic dependence," an emotional desire, craving or compulsion to obtain and experience the drug; and of "tolerance," a physical adjustment to the drug that results in successive doses producing smaller effects and, therefore, in a tendency to increase doses. Statutes speak of habitual use; of loss of the power of self-control respecting the drug; and of effects determental to the individual or potentially harmful to the public morals, safety, health or welfare.[4]

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[1] Cf. PROCEEDINGS, WHITE HOUSE CONFERENCE ON NARCOTIC AND DRUG ABUSE, Washington, D.C., Sept. 27–28, 1962 (hereinafter cited as PROCEEDINGS).

[2] PRES.'S ADVISORY COMM'N ON NARCOTICS AND DRUG ABUSE, FINAL REP. (1963).

[3] Id. at 70–73, 43–44.

[4] On the general problem of defining addiction, see Lindesmith, *Basic Problems in the Social Psychology of Addiction and a Theory*, in NARCOTICS ADDICTION 91, 92–95 (O'Donnell & Ball eds. 1966).

Some drugs are addicting, and some persons are addicted, by one definition but not by another. The World Health Organization Expert Committee on Addiction-Producing Drugs has recommended that the term "drug dependence," with a modifying phrase linking it to a particular type of drug, be used in place of the term "addiction."[5] But "addiction" seems too deeply imbedded in the popular vocabulary to be expunged. Most frequently, it connotes physical dependence, resulting from excessive use of certain drugs. However, it should be noted that one can become physically dependent on substances, notably alcohol, that are not considered part of the drug abuse problem. It should be noted also that psychic or emotional dependence can develop to any substances, not only drugs, that affect consciousness and that people use for escape, adjustment or simple pleasure.

NARCOTICS

The dictionary defines a "narcotic" as a substance that induces sleep, dulls the senses, or relieves pain. In law, however, it has been given an artificial meaning. It does not refer, as might be expected, to one class of drugs, each having similar chemical properties or pharmacological effects. It is applied rather to a number of different classes of drugs that have been grouped together for purposes of legal control. Under the Federal laws, narcotics include the opiates and cocaine.[6] Under most State statutes, marihuana is also a narcotic.[7]

The Opiates. These drugs have a highly technical legal definition,[8] but for purposes of this chapter they may be taken to include opium, morphine, their derivatives and compounds and their synthetic equivalents. The opiates have great medical value. They differ widely in their uses, effects, and addiction potential. The most common are morphine and codeine.[9] The former is a principal drug in the relief of pain, the latter in the treatment of cough. Many opiates are prescribed for use in approved medical settings. While the misuse or illicit use (drug "abuse" includes both) of some of these drugs has presented serious problems for State and Federal enforcement agencies, public concern as to the opiates is focused primarily on heroin, a morphine derivative. This is the chief drug of addiction in the United States.[10]

The effect of any drug depends on many variables, not the least of which are the mood and expectation of the taker.[11] Drug effects are therefore best expressed in terms of probable outcomes. The discussion here is selective rather than exhaustive. With these provisos, it may be said that heroin is a depressant. It relieves anxiety and tension and diminishes the sex, hunger, and other primary drives. It may also produce drowsiness and cause inability to concentrate, apathy, and lessened physical activity. It can impair mental and physical performance. Repeated and prolonged administration will certainly lead to tolerance and physical dependence.

This process is set in motion by the first dose. An overdose may lead to respiratory failure, coma and death. With dosages to which a person is tolerant, permanent organic damage does not occur. However, secondary effects, arising from the preoccupation of a person with the drug, may include personal neglect and malnutrition. The ritual of the American addict is to inject the drug intravenously with a needle, and infections and abscesses may be caused by the use of unsterile equipment. Euphoria is an effect often associated with heroin, often reflecting the relief a particular individual gets from chronic anxiety. Among the symptoms of the withdrawal sickness, which reaches peak intensity in 24 to 48 hours, are muscle aches, cramps, and nausea.[12]

The Bureau of Narcotics maintains a name file of active opiate addicts. As of December 31, 1965, there were 52,793 heroin addicts (out of a total of 57,199 opiate addicts) listed.[13] Most of the names in the file are of persons arrested by State and local police agencies and reported voluntarily to the Bureau on a form the Bureau provides for this purpose. Thus the inclusion of a person's name in the file depends in large measure on his coming to the attention of the police, being recognized and classified as an addict, and being reported. There is some uncertainty at each step. Moreover, some police agencies and many health and medical agencies do not participate in the voluntary reporting system. There is also no place in the system for persons who use opiates without becoming addicted. For these reasons many people feel that the Bureau's file does not present a complete statistical picture of opiate use in this country.[14] Indeed the Bureau makes no claims of infallibility for the reporting system. It is intended as a device for arriving at a workable estimate of the extent and concentration of opiate addiction. The Commissioner of Narcotics has testified numerous times that the Bureau's figures are only approximations.[15] The State of California is another source for statistics on drug addiction; it maintains a file of addicts-users in the State.

It should also be noted that other estimates of the present addict population, some of which cite figures as high as 200,000, are without a solid statistical foundation.[16]

More than one-half the known heroin addicts are in New York. Most of the others are in California, Illinois, Michigan, New Jersey, Maryland, Pennsylvania, Texas, and the District of Columbia.[17] In the States where heroin addiction exists on a large scale, it is an urban problem. Within the cities it is largely found in areas with low average incomes, poor housing, and high delinquency. The addict himself is likely to be male, between the ages of 21 and 30, poorly educated and unskilled, and a member of a disadvantaged ethnic minority group.[18]

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[5] Eddy, Halbach, Isbell & Seevers, *Drug Dependence: Its Significance and Characteristics*, 32 BULL. WLD. HLTH. ORG. 721, 722 (1965).

[6] INT. REV. CODE OF 1954, § 4731(a).

[7] UNIFORM NARCOTIC DRUG ACT § 1(14).

[8] INT. REV. CODE OF 1954, § 4731(g)(1).

[9] See generally U.S. TREASURY DEP'T, TRAFFIC IN OPIUM AND OTHER DANGEROUS DRUGS 54–55 (1965); PERMANENT CENTRAL NARCOTICS BOARD, REPORT TO THE ECONOMIC AND SOCIAL COUNCIL ON THE WORK OF THE BOARD 15–43 (1966); PERMANENT CENTRAL NARCOTICS BOARD, REPORT TO THE ECONOMIC AND SOCIAL COUNCIL ON THE WORK OF THE BOARD 15–43 (1965).

[10] AMA Council on Mental Health, *Report on Narcotic Addiction*, in AMA, NARCOTICS ADDICTION—OFFICIAL ACTIONS OF THE AMERICAN MEDICAL ASSOCIATION 11 (1963). See also PROCEEDINGS 280–91 (Report of an Ad Hoc Panel on Drug Abuse).

[11] Id. at 275. See also Blum, assisted by Funkhouser-Balkaby, *Mind-Altering Drugs and Dangerous Behavior: Dangerous Drugs*, published as appendix A–1 in this volume [hereinafter cited as Blum, *Dangerous Drugs*]; Blum, assisted by Lauraine Braunstein, *Mind-Altering Drugs and Dangerous Behavior: Narcotics*, published as appendix A–2 in this volume [hereinafter cited as Blum, *Narcotics*].

[12] For a discussion of the effects of heroin, see id. at 280–81; Eddy, Halbach, Isbell & Seevers, supra note 5, at 724–25; Isbell, *Medical Aspects of Opiate Addiction*, in NARCOTIC ADDICTION, op. cit. supra note 4, at 62 (1966); MAURER & VOGEL, NARCOTICS AND NARCOTIC ADDICTION 73–87 (2d ed. 1962); AMA Council on Mental Health, supra note 10, at 11–13.

[13] U.S. TREASURY DEP'T, TRAFFIC IN OPIUM AND OTHER DANGEROUS DRUGS 37–46 (1965).

[14] ELDRIDGE, NARCOTICS AND THE LAW 68–78 (1962); LINDESMITH, THE ADDICT AND THE LAW 99–134 (1965); Winick, *Epidemiology of Narcotics Use*, in NARCOTICS 3–6 (Wilner & Kassebaum eds. 1965); Chein, *The Use of Narcotics as a Personal and Social Problem*, id. at 103–08.

[15] *E.g.*, *Hearings on S. 2113, S. 2114, S. 2152 Before a Special Subcommittee of the Senate Judiciary Committee*, 89th Cong., 2d Sess. 455–56 (1966); *Hearings on Organized Crime and Illicit Traffic in Narcotics Before the Permanent Subcommittee on Investigations of the Senate Government Operations Committee*, 88th Cong., 1st & 2d Sess., pt. 3, at 670 (1964).

[16] PROCEEDINGS 290–91 (Report of an Ad Hoc Panel on Drug Abuse).

[17] U.S. TREASURY DEP'T, TRAFFIC IN OPIUM AND OTHER DANGEROUS DRUGS 37, 43 (1965).

The cost of heroin to the addict fluctuates over time and from place to place. So does the quality of the drug. Five dollars is a commonly reported price for a single "bag" or packet of heroin. The substance purchased ranges in purity from 1 to about 30 percent, the remainder consisting of natural impurities, and adulterants such as lactose and mannitol.[19] Usually the addict does not know the strength of the doses he buys. Today, however, the drug available on the street is generally so far diluted that the typical addict does not develop profound physical dependence, and therefore does not suffer serious withdrawal symptoms.[20]

The basic Federal control law, the Harrison Narcotic Act of 1914, is a tax statute.[21] It is administered by the Bureau of Narcotics, an agency of the Treasury Department. The statute imposes a tax upon the manufacture or importation of all narcotic drugs. Payment of the tax is evidenced by stamps affixed to the drug containers. The statute authorizes transfers of narcotics in the original containers by and to persons who have registered with the Treasury Department and paid certain occupational taxes ranging from $1 to $24 a year. Official order forms must be used in completing these transactions. There is an exception for the physician acting in the course of his professional practice. Unauthorized possession under the statute is a criminal offense, whether or not the drug is intended for personal use. Unauthorized sale or purchase is a criminal offense. Unauthorized importation is made punishable by a separate Federal statute.[22] Unauthorized possession and sale are also criminal acts under the Uniform Narcotic Drug Act, the control statute in effect in most States.[23]

Heroin occupies a special place in the narcotics laws. It is an illegal drug in the sense that it may not be lawfully imported or manufactured under any circumstances,[24] and it is not available for use in medical practice. All the heroin that reaches the American user is smuggled into the country from abroad, the Middle East being the reputed primary point of origin. All heroin transactions, and any possession of heroin, are therefore criminal. This is not because heroin has evil properties not shared by the other opiates. Indeed, while it is more potent and somewhat more rapid in its action, heroin does not differ in any significant pharmacological effect from morphine.[25] It would appear that heroin is outlawed because of its special attractiveness to addicts and because it serves no known medical purpose not served as well or better by other drugs.

Cocaine. This drug is included as a narcotic under Federal and other laws but, unlike the opiates, it is a powerful stimulant and does not create tolerance or physical dependence. It is derived from the leaves of the coca plant cultivated extensively in parts of South America. At present it is not the major drug of abuse that it once was.[26]

Marihuana. This is a preparation made from the flowering tops of the female hemp plant. This plant often is found growing wild, or it can be cultivated, in any temperature or semitropical climate, including the United States. Most of the marihuana that reaches American users comes from Mexico. There it is cut, dried, and pulverized and then smuggled across the border, either loose or compressed in brick form. It is commonly converted into cigarettes and consumed by smoking. Other derivatives of the hemp plant, such as hashish, which are more potent than marihuana, are rarely found in the United States.[27]

Marihuana has no established and certainly no indispensable medical use. Its effects are rather complicated, combining both stimulation and depression. Much of its effect depends on the personality of the user. The drug may induce exaltation, joyousness and hilarity, and disconnected ideas; or it may induce quietude or reveries. In the inexperienced taker it may induce panic. Or, one state may follow the other. Confused perceptions of space and time and hallucinations in sharp color may occur; the person's complex intellectual and motor functions may be impaired. These effects may follow within minutes of the time the drug is taken. The influence usually wears off within a few hours but may last much longer in the case of a toxic dose. The immediate physiological effects may include nausea and vomiting, but there are no lasting physical effects, and fatalities have not been noted. Tolerance is very slight if it develops at all. Physical dependence does not develop.[28]

There is no reliable estimate of the prevalence of marihuana use. To the limited extent that police activity is an accurate measure, use appears to be increasing. Bulk seizures of marihuana by Federal enforcement authorities totaled 5,641 kilograms in 1965 as against 1,890 kilograms in 1960.[29] Bureau of Narcotics arrests for marihuana offenses about doubled over the same period of time.[30] So did the number of arrests by California authorities.[31]

Marihuana use apparently cuts across a larger segment of the general population than does opiate use, but again adequate studies are lacking. An impressionistic view, based on scattered reports, is that use is both frequent and increasing in depressed urban areas, academic and artistic communities, and among young professional persons. There are many reports of widespread use on campuses, but estimates that 20 percent or more of certain college populations have used the drug cannot be verified or refuted.[32]

Marihuana is much cheaper than heroin. The director of the Vice Control Division, Chicago Police Department, testified in 1966 that the price of marihuana in Chicago was roughly 50 to 75 cents for a single cigarette, roughly $25 for a can the size of a tobacco tin, and from $85 to $125 a pound.[33] Prices tend to be lower nearer the Mexican source.

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[18] Id. at 41; PROCEEDINGS 293–95 (Report of an Ad Hoc Panel on Drug Abuse); Winick, *Epidemiology of Narcotics Use*, in NARCOTICS, op. cit. supra note 14. CALIFORNIA NARCOTICS REHABILITATION ADVISORY COUNCIL, SECOND ANNUAL REPORT (1966); PUBLIC HEALTH SERVICE, DIVISION OF HOSPITALS ANNUAL STATISTICAL SUMMARY FOR FISCAL YEAR 1965, pt. 2, at 207–23. See also Blum, *Narcotics*.

[19] See, e.g., testimony of Henry L. Giordano, Comm'r, Federal Bureau of Narcotics, in *Hearings on S. 2113, S. 2114, S. 2152*, supra note 15, at 453; testimony of Patrick J. McCormack, Dep. Chief Insp. and Comm. Officer, Narcotics Bureau, New York City Police Dep't, in *Hearings on Organized Crime and Illicit Traffic in Narcotics*, supra note 15, at 733.

[20] PROCEEDINGS 281 (Report of an Ad Hoc Panel on Drug Abuse).

[21] INT. REV. CODE OF 1954, §§ 4701–36.

[22] 21 U.S.C. §§ 171–185 (1964).

[23] UNIFORM NARCOTIC DRUG ACT § 2.

[24] 21 U.S.C. §§ 173, 502, 505 (1964).

[25] PROCEEDINGS 280–81 (Report of an Ad Hoc Panel on Drug Abuse); AMA Council on Mental Health, supra note 10, at 11.

[26] PROCEEDINGS 285–86 (Report of an Ad Hoc Panel on Drug Abuse).

[27] See generally MAURER & VOGEL, supra note 12, at 103–08; Winick, *Marihuana Use by Young People*, in DRUG ADDICTION IN YOUTH (Harms ed. 1965).

[28] Eddy, Halbach, Isbell & Seevers, supra note 5, at 728–29; Winick, *Marihuana Use by Young People*, in DRUG ADDICTION IN YOUTH (Harms ed. 1965); PROCEEDINGS 286 (Report of an Ad Hoc Panel on Drug Abuse); Blum, *Dangerous Drugs*.

[29] Compare U.S. TREASURY DEP'T, TRAFFIC IN OPIUM AND OTHER DANGEROUS DRUGS 51 (1965), with U.S. TREASURY DEP'T, TRAFFIC IN OPIUM AND OTHER DANGEROUS DRUGS 72 (1960).

[30] Compare U.S. TREASURY DEP'T, TRAFFIC IN OPIUM AND OTHER DANGEROUS DRUGS 47 (1965), with U.S. TREASURY DEP'T, TRAFFIC IN OPIUM AND OTHER DANGEROUS DRUGS 69 (1960).

[31] Cal. Dep't of Justice, 1965 Drug Arrests in California: A Preliminary Survey 4 (unpublished draft).

[32] New York Medicine, May 5, 1966, p. 3. See also Blum, *Dangerous Drugs*.

The Federal law controlling marihuana is a tax statute, enacted in 1937 and enforced by the Bureau of Narcotics.[34] On its face the statute authorizes marihuana transactions between persons, such as importers, wholesalers, physicians, and others, who have paid certain occupational and transfer taxes. But in fact, since there is no accepted medical use of marihuana, only a handful of people are registered under the law, and for all practical purposes the drug is illegal. Unauthorized possession, which in this context means possession under almost any circumstance, is a criminal act under Federal tax law. Sale or purchase of marihuana are also criminal offenses under this statute. Importation is made punishable by a separate statute.[35] Possession and sale are also offenses under the Uniform Narcotic Drug Act, which controls marihuana in most States.

DANGEROUS DRUGS

The term "dangerous drugs" commonly refers to three classes of nonnarcotic drugs that are habit-forming or have a potential for abuse because of their stimulant, depressant or hallucinogenic effect. Central nervous system stimulants and depressants are widely used in medical practice and are not considered dangerous when taken in ordinary therapeutic doses under medical direction. They are available on prescription. Drugs in the hallucinogenic class have not yet been proven safe for medical purposes and are not legally available in drugstores. Their sole legitimate use at present is by qualified researchers in connection with investigations reported to and authorized by the Food and Drug Administration.[36] There is an exception in the case of peyote, the use of which is authorized in connection with religious ceremonies of the Native American Church.[37]

THE STIMULANTS

The most widely used and abused of the stimulants are the amphetamines, which are known generally as "pep pills." They bear chemical names such as amphetamine sulfate or dextroamphetamine sulfate and particular nicknames such as "bennies" or "dexies" (after trade names of the two drugs.) There are dozens of amphetamine preparations in the market. They are prescribed and apparently are medically effective for relief of fatigue, for control of overweight, and in the treatment of mental disorder.

The amphetamines cause wakefulness and have the capacity to elevate mood and to induce a state of well-being and elation. This is probably the basis of their medical value. It is also the likely reason for their abuse.

Tolerance develops with the use of amphetamines. This permits gradual and progressive increases in dosage. Too large a dose or too sudden an increase in dose, however, may produce bizarre mental effects such as delusions or hallucinations. These effects are more likely if the drug is injected intravenously in diluted powder form than if it is taken orally in tablet form. Nervousness and insomnia are milder symptoms of abuse. Physical dependence does not develop.[38]

THE DEPRESSANTS

The most widely used and abused of the depressant drugs are the barbiturates. These are known generally as "goofballs." They have chemical names, such as pentobarbital sodium and secobarbital sodium, and particular nicknames, such as "nimbies" and "seccy" (after trade names of the two drugs). There are more than 25 barbiturates marketed for clinical use. They are apparently useful because of their sedative, hypnotic, or anesthetic actions and are most commonly prescribed to produce sleep and to relieve tension and anxiety.

A person can develop tolerance to barbiturates, enabling him to ingest increasing quantities of the drug up to a limit that varies with the individual. Chronic administration of amounts in excess of the ordinary daily dose will lead to physical dependence, resulting, upon withdrawal of the drug, in a sickness marked at peak intensity by convulsions and a delirium, resembling alcoholic delirium tremens or a major psychotic episode. Excessive doses may also result in impairment of judgment, loss of emotional control, staggering, slurred speech, tremor, and occasionally coma and death. Barbiturates are a major suicidal agent. They are also reported, like the amphetamines, to be implicated in assaultive acts and automobile accidents.[39]

Among the other depressants involved in the drug abuse problem are a number of sedative and tranquilizing drugs, introduced since 1950, that are chemically unrelated to the barbiturates, but similar in effect. The best known of these are meprobamate (Miltown, Equanil), glutethimide (Doriden), ethinamate (Valmid), ethchlorvynol (Placidyl), methyprylon (Noludar), and chlordiazepoxide (Librium). There is strong evidence that abuse of these agents may lead to drug intoxication and physical dependence. Suicide by overdose, and deaths during withdrawal from some of the drugs, have also been reported.[40]

THE HALLUCINOGENS

Hallucinogenic, or psychedelic, drugs and the controversy that surrounds them have recently aroused the attention of the mass media and the public. This is certainly due in part to the increasing incidence of their use on college campuses. It may also be due to the emergence of new substances, such as LSD, many times more potent than such older hallucinogens as peyote and mescaline. All these drugs have the capacity to produce altered states of consciousness. Generally they are taken orally.

LSD, the most potent of the hallucinogens, is a synthetic drug made by a chemical process; lysergic acid is the main component in the chemical conversion. Minute amounts of the drug are capable of producing extreme effects. It is usually deposited on sugar cubes in liquid form, although recently it has been found frequently in pill form.[41] Swallowing such a cube or pill is called "taking a trip." A recent publication of the Medical Society of the County of New York described such a trip as follows:

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[33] *Hearings on S. 2113, S. 2114, S. 2152*, supra note 15, at 185 (testimony of John J. Neurauter).

[34] INT. REV. CODE OF 1954, §§ 4741–76.

[35] 21 U.S.C. § 176a (1964).

[36] Goddard, *The Menace of Drug Abuse*, American Education, May 1966.

[37] The controlling regulation may be found in 21 C.F.R. § 166.3.

[38] For a discussion of the effects of amphetamine abuse, see Eddy, Halbach, Isbell & Seevers, supra note 5, at 729–30; AMA Comm. on Alcoholism and Addiction and Council on Mental Health, *Dependence on Amphetamines and Other Stimulant Drugs*, 197 J.A.M.A. 1023 (1966); PROCEEDINGS 286–88 (Report of an Ad Hoc Panel on Drug Abuse); Blum, *Dangerous Drugs*.

[39] For a discussion of the effects of barbiturate abuse, see Eddy, Halbach, Isbell & Seevers, supra note 5, at 725–27; AMA Comm. on Alcoholism and Addiction and Council on Mental Health, *Dependence on Barbiturate and Other Sedative Drugs*, 193 J.A.M.A. 673 (1965); PROCEEDINGS 283–85 (Report of an Ad Hoc Panel on Drug Abuse); Fort, *The Problem of Barbiturates in the United States of America*, 16 Bull. on Narcotics, Jan.–March 1964, p. 17, reprinted in *Hearings on H.R. 2 Before the House Interstate and Foreign Commerce Committee*, 89th Cong., 1st Sess., p. 66 (1965); Blum, *Dangerous Drugs*.

[40] For discussion of the effects of these drugs when abused, see AMA Comm. on Alcoholism and Addiction and Council on Mental Health, *Dependence on Barbiturates and Other Sedative Drugs*, 193 J.A.M.A. 673 (1965); Essig, *Addiction to Nonbarbiturate Sedative and Tranquilizing Drugs*, 5 Clinical Pharmacology and Therapeutics, May–June 1964, p. 334, reprinted in *Hearings on H.R. 2*, supra note 39, at 33. See also Blum, *Dangerous Drugs*.

> *After the cubes, containing 100–600 mcg.* [*a microgram is one-millionth of a gram*] *each, are ingested a startling series of events occurs with marked individual variation. All senses appear sharpened and brightened; vivid panoramic visual hallucinations of fantastic brightness and depth are experienced as well as hyperacusis* [*abnormal acuteness of hearing*]. *Senses blend and become diffused so that sounds are felt, colors tasted; and fixed objects pulsate and breathe. Depersonalization also occurs frequently so that the individual loses ego identity; he feels he is living with his environment in a feeling of unity with other beings, animals, inanimate objects and the universe in general. The body image is often distorted so that faces, including the user's, assume bizarre proportions and the limbs may appear extraordinarily short or elongated. The user is enveloped by a sense of isolation and often is dominated by feelings of paranoia and fear. If large doses are ingested* (*over 700 mcg.*) *confusion and delirium frequently ensue. During LSD use, repressed material may be unmasked which is difficult for the individual to handle. Duration of the experience is usually 4 to 12 hours but it may last for days.*[42]

The same publication cited as dangers of LSD: (1) Prolonged psychosis; (2) acting out of character disorders and homosexual impulses; (3) suicidal inclinations; (4) activation of previously latent psychosis; and (5) reappearance of the drug's effects weeks or even months after use. It was reported that between March and December of 1965 a total of 65 persons suffering from acute psychosis induced by LSD were admitted to Bellevue Hospital in New York.[43]

The only legal producer of LSD ceased manufacture in April 1966, and turned over its entire supply of the drug to the Federal Government. A few closely monitored experimental projects involving LSD are still in progress.[44]

Peyote is the hallucinogenic substance obtained from the button-shaped growths of a cactus plant found growing wild in the arid regions of Mexico. Mescaline is a natural alkaloid, which occurs in the same plant. These drugs have appeared in capsule and liquid form and as a powder that can be dissolved in water.[45]

Psilocybin is a substance extracted from a mushroom fungus. It appears in liquid and powder form.[46]

Different degrees of tolerance to the hallucinogens are reported. Physical dependence apparently does not develop.[47]

There is no reliable statistical information on the prevalence of dangerous drug abuse. However, there are indications of widespread and increasing abuse. The former Commissioner of the Food and Drug Administration, for example, has testified that enough raw material was produced in 1962 to make over 9 billion doses of barbiturates and amphetamines combined, and he estimated that one-half of these ended up in the bootleg market.[48] There is no similar estimate of the proportion of the more than 1 million pounds of tranquilizer drugs produced each year that fall into the hands of drug abusers, but the figure certainly is high. A spreading use of the hallucinogens has undoubtedly been caused in part by the activities and advertising of groups formed for the very purpose of promoting experience in these drugs. These groups, or cults, have made broad and appealing claims in regard to the capacity of the hallucinogens to expand the power of the mind to understand self, love, God, and the universe.[49] They are likely to understate the dangers that line the route to such mystical experiences. Whatever the other causes, cases of dangerous drug abuse coming to the attention of school and medical authorities and police officials have been steadily increasing in number.[50] The prices of illicit dangerous drugs vary sharply in time and place. Some approximate ranges of reported price are from $0.10 to $1 for an amphetamine or barbiturate tablet, from $1 to $10 for a sugar cube saturated with LSD, and from $0.01 to $0.50 for a peyote button.[51] All of these prices represent significant profits to the seller.

A series of Federal enactments that proved inadequate to deal with the traffic in dangerous drugs has given way to the Drug Abuse Control Amendments of 1965.[52] The statute became effective February 1, 1966, and is now the principal Federal law in the field. It limits manufacture, sale, and distribution of any controlled drug to certain designated classes of persons, such as registered wholesale druggists and licensed physicians. It requires that inventories be taken and records of receipts and dispositions be maintained. It places restrictions on the refilling of prescriptions. Criminal penalties are provided for violations, including manufacture, sale, or distribution by unauthorized persons. The first offense is a misdemeanor; the second, a felony. Possession of drugs for personal use is not an offense under this statute.

All of the amphetamines and the barbiturates are controlled by specific language in the statute. In addition, any other drug with potential for abuse because of its depressant, stimulant, or hallucinogenic effect may be placed under control by designation. Some 22 other drugs have been so designated, including all of the hallucinogens and three of the tranquilizers discussed above. The statute is enforced by the Bureau of Drug Abuse Control, a newly created agency within the Food and Drug Administration.

Almost all States have some statutory scheme for controlling at least some of the dangerous drugs, but there is complete lack of uniformity in this legislation.

It is obvious that the increasing use of drugs, including particularly those like LSD with great potential for harm, presents a serious challenge to the Nation.

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[41] See generally the testimony of James L. Goddard, Comm'r, Food and Drug Administration, in *Hearings on S. 2113, S. 2114, S. 2152*, supra note 15, at 320.

[42] New York Medicine, May 5, 1966, p. 5.

[43] Id. at 5–7.

[44] *Hearings on S. 2113, S. 2114, S. 2152*, supra note 15, at 330 (testimony of Comm'r Goddard).

[45] See Ludwig & Levine, *Patterns of Hallucinogenic Drug Abuse*, 191 J.A.M.A. 92 (1965).

[46] Id. at 93.

[47] Id. at 95–96; Eddy, Halbach, Isbell & Seevers, supra note 5, at 731.

[48] *Hearings on H.R. 2*, supra note 39, at 23 (statement of George P. Larrick). See also Goddard, supra note 36.

[49] See, e.g., the testimony of Arthur Kleps, Dir., Neo-American Church, in *Hearings on S. 2113, S. 2114, S. 2152*, supra note 15, at 413. There are also books and magazines (such as the PSYCHEDELIC REVIEW) which describe and promote experiences with hallucinogenic drugs.

[50] E.g., statement of John J. Neurauter, Dir., Vice Control Div., Chicago Police Dep't, in *Hearings on S. 2113, S. 2114, S. 2152*, supra note 15, at 181, 186–87. See also Blum, *Dangerous Drugs*.

[51] Ludwig & Levine, supra note 45, at 93; New York Medicine, May 5, 1966, pp. 4–5; Blum, *Dangerous Drugs*.

[52] Pub. L. No. 89–74 (July 15, 1965).

The Commission recommends:

Research should be undertaken devoted to early action on the further development of a sound and effective framework of regulatory and criminal laws with respect to dangerous drugs. In addition, research and educational programs concerning the effects of such drugs should be undertaken.

ENFORCEMENT

Drug enforcement is a question of finding the drugs and the people in the illicit traffic. Both tasks are formidable.

THE DRUGS

Different enforcement considerations are presented by the opiates (meaning heroin for purposes of this section) and marihuana on the one hand, and the dangerous drugs on the other. To get the former into the country requires an illegal act of smuggling, and their possession and sale in virtually every circumstance are criminal offenses over which the State and Federal governments have concurrent jurisdiction. The dangerous drugs for the most part enter the illicit market by way of diversion from domestic supplies. Simple possession of these drugs is not an offense under any Federal statute. Under State law it may or may not be an offense, depending on the State and the drug involved. It should also be noted that not all abuse of dangerous drugs stems from an illicit traffic. Abuse may occur, for example, if a dose of barbiturates greater than that called for in a legal prescription is taken. Not even perfect and total enforcement of the drug laws could prevent abuse of this kind.

By multiplying the number of known addicts by an average daily dose, the Federal enforcement agencies have arrived at the very rough estimate that 1,500 kilograms (1 kilo=2.2 pounds) of heroin a year are smuggled into the United States. On the average, less than one-tenth of this amount is seized by all enforcement agencies combined. The principal foreign sources are thought to be Turkey and to a much lesser extent Mexico and the Far East. In Turkey, the poppy is cultivated legally, and its opium (heroin is a refined product of opium) is an important export commodity; but a substantial part of the annual crop is diverted by the farmer from the government monopoly to the black market, where it brings double the price. In Mexico the cultivation of the opium poppy is itself illicit. It takes place in remote and mountainous terrain.

Raw opium diverted in Turkey is converted to morphine base at points near its source, reducing its bulk by a factor of 10, and then forwarded to clandestine chemical laboratories, mostly in France, for processing into heroin. The finished product is then smuggled into the United States, either directly or indirectly through Canada or Mexico, and proceeds on its course to the consumer. The heroin becomes less pure and more expensive as it moves through the illicit channels of distribution. The same 10 kilos of opium, which are purchased from the Turkish farmer at the black-market price of roughly $350, and which are sufficient to produce roughly 1 kilo of pure (in this context about 85 percent) heroin, reach the American addict as thousands of doses of substance containing 1 to 30 percent heroin and costing $225,000 or more.[53]

The estimated 1,500 kilograms of heroin illegally entering the country each year represent less than one-half of 1 percent of the licit opium production in the world, and an even smaller fraction of the combined licit and illicit production. The problem is thus how to block a small flow from a vast supply. To do this, the Bureau of Narcotics maintains 12 posts of duty in three overseas districts. Nineteen agents were assigned to these posts at the end of fiscal 1966. They work with authorities in the host country in attempting to locate and seize illicit opium and heroin supplies destined for the United States. This effort has had considerable success. In 1965, for example, the agents assisted in 82 investigations, which resulted in the seizure of 888 kilograms of raw opium, 128 kilograms of morphine base, and 84 kilograms of heroin.[54] But the effort has obvious limitations. It is somewhat like trying to dam a river at its widest point with much too little material.

The Bureau of Customs maintains a force at ports and along land borders to protect the revenue and to detect and prevent smuggling of contraband, including illicit drugs. This is not solely an enforcement task. Many nonenforcement personnel such as examiners, verifiers, and appraisers of merchandise are involved. Also in the nonenforcement category, although they play a vital role in the suppression of smuggling, are the inspectors, some 2,600 of whom were on the customs rolls at the end of fiscal 1966. These men handle the inspection of persons, their vehicles, and their effects arriving from abroad. In 1965 more than 180 million persons and 53 million vehicles and trains arrived in the United States.[55] Obviously nothing more than a cursory inspection of most of them was possible. Such inspections are not well designed to uncover illicit drugs, which are generally small in bulk and cleverly concealed, but they often do lead to significant seizures and probably deter countless smuggling violations.

The customs' enforcement arm is the Customs Agency Service. This is composed of: (1) Customs port investigators and customs enforcement officers. There were 492 such men on duty at the end of fiscal 1966. They conduct vessel and aircraft searches (more than 99,000 vessels and 210,000 aircraft arrived in the United States in 1965 [56]), perform uniformed patrol in marked vehicles and carry out plainclothes assignments and surveillances at airports, piers, and border crossing points. (2) Customs agents. These men, 276 of whom were assigned at the end of fiscal 1966, are the top-echelon criminal investigators within the Bureau. They develop intelligence and evidence concerning violations of the criminal statutes within customs enforcement jurisdiction.

Some 65 kilograms of heroin and other illicit narcotics excluding marihuana were seized at ports and borders in fiscal 1966.[57] Approximately one-half of all 1966 customs seizures of illicit drugs resulted from prior information received from informants.[58]

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[53] An informative discussion of the flow and handling of heroin in the illicit channels may be found in the *Hearings on Organized Crime and Illicit Traffic in Narcotics*, supra note 15 (pts. 1–5). The international aspects of the traffic are described most fully in part 4 of the hearings. See also Economic and Social Council Comm'n on Narcotic Drugs, Draft Report of the Work of the Twenty-first Session, ch. III, Illicit Traffic, Dec. 14, 1966.

[54] U.S. TREASURY DEP'T, TRAFFIC IN OPIUM AND OTHER DANGEROUS DRUGS 26 (1965).

[55] *Hearings on Treasury Appropriations for 1967 Before a Subcommittee of the House Appropriations Committee*, 89th Cong., 2d Sess. 413 (1966).

[56] Ibid.

Once heroin enters the country, unless it is seized quickly in the hands of the courier, the job of finding it in significant quantities becomes even more difficult. This is because it is broken up into smaller lots and diluted as it moves through the channels of distribution. Enforcement against the upper echelons of the traffic is the business of the Bureau of Narcotics, which at the end of fiscal 1966 had a force of 278 agents stationed in 13 districts in the country. Lower echelons of the traffic are targets for State and local narcotics enforcement. An accurate total of the personnel engaged in narcotics enforcement in all States and localities is not available, but the number would probably exceed a thousand. Frequently narcotics enforcement is part of the responsibility of local vice controls squads. Federal agents seized 156 kilograms of illicit opiates and cocaine in the internal traffic in 1965, 95 kilos of heroin coming in a single seizure.[59] No accurate total is available for illicit narcotic seizures by all States and municipal agencies.

Many of the considerations noted above are applicable to the enforcement of the marihuana laws. More than 5,600 kilograms were seized by Federal authorities in 1965, the majority of it by the Bureau of Customs at points of entry along the Mexican border.[60]

Serious Federal enforcement of the drug abuse control amendments is just beginning. A Bureau of Drug Abuse Control has recently been established within the Food and Drug Administration. It now has 200 agents assigned to nine field offices. It hopes to have 500 agents assigned by 1970. State and local enforcement is handled by the narcotic units or vice control squads.

The illicit traffic in depressant and stimulant drugs is quite new, and how it operates is only partially understood. It appears to be fed mainly by diversions from the chain of legitimate drug distribution. Diversions are known to have occurred at all points in the chain from the manufacture of the basic chemicals to delivery of the finished dosage forms of the drug to the consumer. Large quantities of the basic depressant and stimulant powders have been ordered from chemical brokers and dealers by persons using fictitious names, indicating firms engaged in research. In some cases, involving diversions of millions of capsules over periods of a few months, drugs have been sold directly to illegal peddlers by manufacturers of the dosage form. In other cases drugs have been diverted by salesmen of manufacturing or wholesale firms, sometimes through the medium of fictitious drugstores. Again millions of tablets have been involved. Unlawful sales by retail pharmacists and by physicians have occurred. So, of course, have larcenies from plants and thefts from interstate shipments. Apparently unregistered drug manufacturers (whose product duplicates the genuine article in substance) and drug counterfeiters (whose product duplicates the genuine article in appearance only) are also major sources of illicit drugs. Fraudulent means of obtaining drugs, such as forging prescriptions, are also practiced.[61]

The hallucinogens are not available for legitimate distribution. In some cases the drugs are smuggled across the Mexican border. In other cases the raw materials are present in large supply in this country, and supplies of peyote have reputedly been obtained by placing an order with a "cactus company" in Texas.[62] LSD, while it may be produced by a relatively simple chemical process (the raw materials are also under Federal controls [63]), is thought to come frequently from foreign sources, both legal and illegal.[64] The problems of detecting this drug are special ones. It is colorless, tasteless, odorless; one two-hundred and eighty thousandth of an ounce is enough to cause the characteristic effects.[65]

THE PEOPLE

Those involved in illicit drug traffic are either suppliers or consumers. They range from the organized crime boss who organizes 50-kilo heroin shipments, to the college student who smokes a single marihuana cigarette.

The opiate traffic on the east coast is in heroin of European origin and is hierarchical in structure. The importers, top members of the criminal cartels more fully described in chapter 7 of this report dealing with organized crime, do not handle and probably do not ever see a shipment of heroin. Their role is supervisory and financial. Fear of retribution, which can be swift and final, and a code of silence protect them from exposure. Through persons working under their direction the heroin is distributed to high-level wholesalers, who are also members of the cartels. Beyond this point the traffic breaks out of the hands of the organized crime element and becomes increasingly diffuse. Low-level wholesalers are at the next echelon; they are on the neighborhood level. Retailers, street peddlers (who are often themselves addicts) and addicts round out the system.

On the west coast the traffic is in heroin of Mexican origin and is carried on largely by independent operators. The actual smuggling is often done by persons hired for this purpose by the operators.

The marihuana trade resembles the heroin traffic on the west coast. Occasionally the same people are involved, but they are not likely to be major rackeeters, or to have dominant positions in the underworld.

Not enough of the people in the dangerous drug traffic have been caught to form valid judgments about the traffic's personnel. It appears that unregistered manufacturers and wholesalers and bulk peddlers are key figures. It has been alleged, but not proved, that trafficking in these drugs has become an activity of organized crime. Certainly the profits are there in the case of the depressant and stimulant drugs. The hallucinogenic drug traffic appears to be less profit oriented than others.[66]

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[57] Customs Agency Service, Annual Report to the Commissioner of Customs for Fiscal 1966, p. 9.

[58] Id. at 20.

[59] U.S. TREASURY DEP'T, TRAFFIC IN OPIUM AND OTHER DANGEROUS DRUGS 51 (1965).

[60] Ibid. See also Customs Agency Service, Annual Report to the Commission of Customs for Fiscal 1966, p. 9.

[61] The best available account of the dangerous drug traffic may be found in *Hearings on H.R. 2*, supra note 48, at 336 (Food and Drug Administration Staff Memorandum on H.R. 2 Concerning Methods of Diversion of Depressant and Stimulant Drugs With Specimen Cases and Comments on Questions Arising During the Hearing).

[62] Ludwig & Levine, supra note 45, at 94.

[63] See *Hearings on S. 2113, S. 2114, S. 2152*, supra note 15, at 330–31 (testimony of James L. Goddard). See 21 C.F.R. § 166.3.

[64] Staff interview with John Finlator, Dir., Bureau of Drug Abuse Control. See also *Hearings on S. 2113, S. 2114, S. 2152*, supra note 15, at 330–31.

[65] Bureau of Drug Abuse Control, Fact Sheet No. 5, Aug. 25, 1966.

[66] On the people involved in illicit drug traffic generally, see the *Hearings on Organized Crime and Illicit Traffic in Narcotics Before the Permanent Subcommittee on Investigations of the Senate Government Operations Committee*, 88th Cong., 1st & 2d Sess., pt. 3 (1964); *Hearings on S. 2113, S. 2114, S. 2152 Before a Special Subcommittee of the Senate Judiciary Committee*, 89th Cong., 2d Sess. (1966); *Hearings on H.R. 2*, supra note 39.

THE TECHNIQUE

The objectives of law enforcement are to reach the highest possible sources of drug supply and to seize the greatest possible quantity of illicit drugs before use. These are difficult goals, given the fact that drug transactions are always consensual. There are no complaining witnesses or victims; there are only sellers and willing buyers. The enforcement officer must therefore initiate cases. He must find and take up positions along the illicit traffic lanes. The standard technique for doing this is undercover investigation during which an officer assumes another identity for the purpose of gathering evidence or making a "buy" of evidence. The use of informants to obtain leads and to arrange introductions is also standard and essential. An informant may or may not be a person facing criminal charges. If he is not, he may supply information out of motives of revenge or monetary reward. More typically the informant is under charges and is induced to give information in return for a "break" in the criminal process such as a reduction of those charges. Frequently he will make it a condition of cooperation that his identity remain confidential.[67]

The payoff in enforcement is the "big case" against the major violator with executive rank in the traffic. This man is hard to identify and harder to implicate with legal evidence. He has a shield of people in front of him, and by not handling drugs himself he removes his liability to prosecution under laws that prohibit possession, sale, or other such acts. The conspiracy laws are the most useful weapon against such a person, and over the years many important convictions have been obtained under these laws on evidence developed by the Bureau of Narcotics and the Bureau of Customs.

THE RESULTS

Judgments about enforcement results are hard to make. Experience with the opiate laws has been the longest. There are persuasive reasons to believe that enforcement of these laws has caused a significant reduction in the flow of these drugs. The best evidence is the high price, low quality, and limited availability of heroin today as contrasted with the former easy availability of cheap and potent heroin. Arguments based on comparisons of the number of addicts in the general population at different points in time are difficult to assess because of the uncertainties in the estimates being compared. However, there is a widespread conviction that the incidence of addiction in the general population has declined since the enactment and enforcement of the narcotic control laws.[68]

The brunt of enforcement has fallen heavily on the user and the addict. In cases handled by the Bureau of Narcotics, whose activities are directed against international and interstate traffickers, more than 40 percent of the defendants prosecuted are addicts.[69] However, these addicts almost invariably are also peddlers, who are charged with sale rather than mere possession.[70] It is fair to assume that the percentage of addicts among the defendants prosecuted by State and local drug enforcement agencies is even higher. The enforcement emphasis on the addict is due to his constant exposure to surveillance and arrest and his potential value as an informant.

THE NEED TO STRENGTHEN LAW ENFORCEMENT

More customs enforcement is not a simple formula for progress. To begin with, it must be understood that illegal importations of drugs can never be completely blocked. The measures necessary to achieve or even approach this goal, routine body searches being one obvious example, would be so strict and would involve such a burden on the movement of innocent persons and goods that they would never be tolerated. Moreover, the demand and the profits being what they are in the drug traffic, there will always be people willing to take whatever risks are necessary to pass the customs barrier. These conditions make the impact of any enforcement buildup hard to determine in advance. Nevertheless the ports and borders are the neck of the illicit traffic, and it is at these points that the Commission believes a commitment of more men would achieve the most. Illicit drugs regularly arrive at these points in significant quantities and in the hands of people who, while not at the highest, are at least not at the lowest level of the traffic. More frequent interceptions of both the drugs and the people could reasonably be expected if the capacity to enforce customs laws was increased. Other important benefits, in the form of larger revenue collections and the suppression of smuggling generally, would also follow.

Three separate studies of the manpower needs of customs enforcement operations have been made within the last 5 years. Each has arrived independently at the same recommendation: That the enforcement staff be increased by a total of about 600 positions. But only a small fraction of this total has, in fact, been authorized.[71] In the meantime, the overall customs workload, from which the enforcement workload is naturally derived, has increased by 5 or 10 percent a year, a rate exceeding every advance estimate.[72] The need for more enforcement staff is thus more urgent now than ever.

The Commission also believes that increases in the nonenforcement personnel of the Bureau of Customs are necessary. In the decade between 1955 and 1965 the number of people entering the United States increased by 50 percent, the number of aircraft by almost 100 percent. During the same period the number of inspectors who examine incoming passengers and their baggage increased only 4 percent.[73] Examination today is, therefore, less common and less effective. This is but one example of how much faster than its manpower the customs workload has grown. The inspection force should be augmented. If a sufficient number of new positions were created, not only could regular inspections be improved but greater customs coverage of military shipments might also be possible. In addition, roving inspection teams might be formed and used on a random basis to double or triple the inspection strength at particular ports of entry for short periods of time.

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[67] For a discussion of the investigative techniques used in narcotic enforcement, see chs. 6 & 7 of SKOLNICK, JUSTICE WITHOUT TRIAL (1966).

[68] On the decreased quality and availability of heroin, see *Hearings on S. 2113, S. 2114, S. 2152*, supra note 66, at 428, 455; *Hearings on Organized Crime and Illicit Traffic in Narcotics*, supra note 66, at 645; PROCEEDINGS 281 (Report of an Ad Hoc Panel on Drug Abuse). The conviction that the incidence of addiction has declined is universal in the enforcement community, and seems also to be shared by some critics of United States narcotic control laws and enforcement policies. See, *e.g.*, ELDRIDGE, NARCOTICS AND THE LAW 80 (1962).

[69] Testimony of Henry L. Giordano, in *Hearings on S. 2113, S. 2114, S. 2152*, supra note 66, at 448, and in *Hearings on Organized Crime and Illicit Traffic in Narcotics*, supra note 66, at 656–57.

[70] Ibid.

[71] *Hearings on Treasury Appropriations*, supra note 55, at 457 (testimony of Frank Gatchell, Jr., Budget Officer, Bureau of Customs).

[72] Id. at 418–19, 441–44, 452.

[73] Memorandum from Lester D. Johnson, Comm'r of Customs, to David C. Acheson, Spec. Ass't to the Secretary of the Treasury (for Enforcement), Jan. 12, 1966.

Mail examination is another customs activity that suffers from budgetary and manpower limitations. In 1965 only 5.5 percent of 47.6 million foreign mail packages were examined.[74] The Commissioner of Customs testified in 1966 that the rate of examination should be at least 10 percent to insure against the smuggling of illicit drugs and other contraband and to protect the revenues. He estimated that 60 additional employees, at a cost of about $450,000, could be expected to return between $6 and $8 million annually in duty collections.[75] The Commission believes the addition of these employees would be a sound investment and would offer at least potentially valuable law enforcement benefits.

The Commission recommends:

The enforcement and related staff of the Bureau of Customs should be materially increased.

There are no convenient devices, such as the rate of incoming persons or merchandise, to measure the workload of the Bureau of Narcotics. The need for more funds and more staff is thus hard to document. Yet the simple fact is that the Bureau has numerous complex tasks to perform. It bears the major Federal responsibility for suppression of traffic in illicit narcotics and marihuana. It assists foreign enforcement authorities within their own countries. It assists in training local enforcement personnel in this country. It not only enforces the penal statutes relating to narcotics and marihuana but also administers the laws relating to the legitimate importation, manufacture, and distribution of these drugs. The Commission believes that the Bureau's force of some 300 agents, spread across 10 foreign countries and throughout the United States, is not sufficient. It certainly does not enable the Bureau to divert personnel from the business of making arrests, seizing drugs, and obtaining convictions, to the work of intelligence. Yet given the pyramidal structure of the illicit drug traffic and the limited exposure of those at the top, intelligence activity has a vital place in the enforcement effort.

The Commission recommends:

The enforcement staff of the Bureau of Narcotics should be materially increased. Some part of the added personnel should be used to design and execute a long-range intelligence effort aimed at the upper echelons of the illicit drug traffic.

The Commission also notes that the Federal Government undertook responsibility in respect to dangerous drugs with the enactment of the Drug Abuse Control Amendments of 1965. It is essential that adequate resources be provided to the Bureau of Drug Abuse Control to enable it to carry out these responsibilities.

In enacting the 1965 Drug Abuse Control Amendments, Congress sought to control the traffic in dangerous drugs predominantly by a system of registration, inspection, and recordkeeping. The amendments apply to drugs in intrastate as well as interstate commerce. Thus, once a drug has been placed under control of the amendments, State law cannot exempt from regulation even intrastate commerce in that drug.

Existing State laws dealing with dangerous drugs are strikingly dissimilar. In some States there are none at all. In some States nonmedical distribution and possession are criminal offenses, but there are no recordkeeping or other regulatory provisions. In others a version of the Model State Barbiturate Act, or legislation patterned after the Uniform Narcotic Drug Act, is in effect. In still others dangerous drugs are controlled like any other prescription legend drugs. Some State statutes list particular drugs. Others give an enforcement agency authority to designate drugs having certain characteristics.

The Commission believes that effective control of traffic in dangerous drugs requires a joint Federal-State effort. Such an effort, in turn, requires common State and Federal regulatory provisions. With such provisions there could be a pooling of strength and a division of responsibility. A Model State Drug Abuse Control Act is now being distributed to the States by the Food and Drug Administration. Under this act, which automatically subjects a drug to State control upon its designation under the Federal law, State and Federal authorities could immediately combine to control the drug. With common recordkeeping provisions, State authorities could concentrate their inspections on retailers, and Federal authorities on wholesalers.

The Model State Act as drafted is flexible enough to permit States to control drugs not regulated by Federal law and to insert their own provisions respecting possession, penalties, licensing, etc.[76]

The Commission recommends:

Those States which do not already have adequate legislation should adopt a model State drug abuse control act similar to the Federal Drug Abuse Control Amendments of 1965.

The recordkeeping and inspection provisions of the 1965 amendments are at the heart of the Federal dangerous drugs regulatory scheme. They are designed to serve several purposes: To furnish information regarding the extent of the dangerous drug problem and the points in the chain of distribution where diversions of drugs occur; to facilitate the detection of violations; and to deter violations. Yet at present the 1965 amendments specifically state:

> *No separate records, nor set form or forms for any of the foregoing records (of manufacture, receipt, and disposition), shall be required as long as records containing the required information are available.*

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[74] *Hearings on Treasury Appropriations*, supra note 55, at 413.

[75] Id. at 413, 453–54, 459.

[76] For this section, see generally Rosenthal, *Proposals for Dangerous Drug Legislation*, published as appendix B in this volume.

There are about 6,000 establishments, including 1,000 manufacturers and 2,400 wholesalers, which are required to register and keep records under the amendments. In addition, there are about 73,000 other establishments that are required to maintain records but not required to register. This group includes some 54,000 pharmacies or other retail drug outlets, some 9,000 hospitals and clinics, some 8,000 dispensing practitioners, and some 2,000 research facilities.[77] The Commission simply does not believe that a proper and productive audit of such a mass of records is possible without, at the very least, a provision requiring the records to be segregated or kept in some other manner permitting rapid identification and inspection.

The Commission recommends:

The recordkeeping provisions of the 1965 amendments should be amended to require that records must be segregated or kept in some other manner that enables them to be promptly identified and inspected.

DRUG ABUSE AND CRIME

Drug addicts are crime-prone persons. This fact is not open to serious dispute, but to determine its meaning is another matter. Analysis is best restricted to heroin because of the applicable laws, because of the information available, and because drugs with addiction liability present the clearest issues. In order to obtain an accurate idea of the drug-crime relationship, it is necessary to make a clear distinction between the drug offenses and the nondrug offenses committed by addicts.

DRUG OFFENSES

Addiction itself is not a crime. It never has been under Federal law, and a State law making it one was struck down as unconstitutional by the 1962 decision of the Supreme Court in *Robinson* v. *California*.[78] It does not follow, however, that a state of addiction can be maintained without running afoul of the criminal law. On the contrary, the involvement of an addict with the police is almost inevitable. By defintion, an addict has a constant need for drugs, which obviously must be purchased and possessed before they can be consumed. Purchase and possession, with certain exceptions not relevant in the case of an addict, are criminal offenses under both Federal and State law. So is sale, to which many addicts turn to provide financial support for their habits. In many States, the nonmedical use of opiates is punishable, as is the possession of paraphernalia such as needles and syringes designed for such use. In other States, vagrancy statutes make it punishable for a known or convicted addict to consort with other known addicts or to be present in a place where illicit drugs are found.[79]

Thus, the addict lives in almost perpetual violation of one or several criminal laws, and this gives him a special status not shared by other criminal offenders. Together with the fact that he must have continuous contact with other people in order to obtain drugs, it also gives him a special exposure to police action and arrest, and, in areas where the addiction rate is high, a special place in police statistics and crime rate computations.

NONDRUG OFFENSES

The nondrug offenses in which the heroin addict typically becomes involved are of the fund-raising variety. Assaultive or violent acts, contrary to popular belief, are the exception rather than the rule for the heroin addict, whose drug has a calming and depressant effect.

Illicit drugs, as already noted, are expensive. Records compiled by the New York City police are sufficient proof of this. In May 1965, a total of 991 admitted users of heroin were arrested in New York City. The average daily cost of heroin to these users was $14.34. In December of that year, the 1,271 heroin users arrested spent a daily average of $14.04.[80] The price of the drug is not uniform in time or place; it differs in New York and Los Angeles and fluctuates everywhere according to the supply available on the street. But it is never low enough to permit the typical addict to obtain it by lawful means. So he turns to crime, most commonly to the theft of property. Stolen property cannot be converted at full value, especially by an addict who needs to dispose of it quickly. It is said that between $3 and $5 in merchandise must be stolen to realize $1 in cash.[81]

The mathematics of this are alarming. Assuming that each of the heroin addicts in New York City, whose names were on file with the Bureau of Narcotics at the end of 1965, spent $15 a day for his drug, and that in each case the $15 represented the net cash proceeds after conversion of stolen property worth $50, the addicts would be responsible each year for the theft of property valued at many millions of dollars in New York City alone. This amount would, of course, have to be adjusted to take into account the addicts who are in jail or hospitalized; those who obtain the price of heroin either through lawful means or by prostitution, selling of drugs, thefts of cash, or any other method which does not require the conversion of stolen property; and the addicts who are unknown to the authorities. The impact of these adjustments might be enormous but it cannot be accurately measured.

The projected totals are so impressive that they lead one into the easy assumption that addicts must be responsible for most crimes against property where addiction is widespread. But this assumption cannot so easily be verified.

Records compiled by the New York City Police Department indicate that 11.1 percent of those arrested in 1965 for those felonies against property most often committed by addicts were admitted drug (mostly heroin) users. The camparable figure for 1964 was 12.5 percent; for 1963 it was 11.7 percent. The involvement of admitted drug users in arrests for selected felonies against the person was much lower—on the order of 2 percent. The 1965 figure for the involvement of admitted drug users in arrests for petit larceny was 9.8 percent.[82] It is impossible to judge what any of these figures might have been if they had reflected involvement in nondrug offenses of actual instead of admitted drug users.

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[77] Staff interview with John Finlator, Dir., Bureau of Drug Abuse Control.

[78] 370 U.S. 660 (1962).

[79] ELDRIDGE, NARCOTICS AND THE LAW 149–93 (app. B) (1962).

[80] New York City Police Dep't Statistical and Records Bureau, Statistical Report of Narcotic Arrests and Arrests of Narcotic Users, 1964–1965.

[81] See, e.g., testimony of Henry L. Giordano & Patrick J. McCormack, *Hearings on Organized Crime and Illicit Traffic in Narcotics*, supra note 66, at 677, 739–40.

For the fiscal years 1956–65 inclusive, an average of 8 percent of all persons committed to Federal prisons and other penal institutions had an admitted drug (again mostly heroin) use history. On the other hand, the New York City Department of Corrections reports that surveys taken of its average 1966 population (about 10,000 persons) show that almost 40 percent had an admitted history of drug use.[83]

As of December 31, 1966, there were 4,385 persons identified as users of heroin in the FBI's "Careers in Crime Program"—a computerized record of criminal histories. This data is based on criminal fingerprint cards submitted by local and Federal agencies.

The 4,385 people who were identified as heroin users had an average criminal career (the span of years between the first and last arrest) of 12 years during which they averaged 10 arrests. Six of these arrests on an average were for offenses other than narcotics. Of the total arrests accumulated by heroin users in the property crime and violent crime categories, 26 percent were arrests for violent crimes and 74 percent were arrests for property crimes. On the other hand, all criminal offenders in the program (over 150,000) averaged 23 percent arrests for violent crimes and 77 percent for property crimes. Seventy-two percent of all heroin users had an arrest for some other criminal act prior to their first narcotic arrest.[84]

The simple truth is that the extent of the addict's or drug user's responsibility for all nondrug offenses is unknown. Obviously it is great, particularly in New York City, with its heavy concentration of users; but there is no reliable data to assess properly the common assertion that drug users or addicts are responsible for 50 percent of all crime.

More broadly, the Commission's examination of the evidence on the causal connection between drug use and crime has not enabled it to make definitive estimates on this important issue. Since there is much crime in cities where drug use is not thought to be a major problem, to commit resources against abuse solely in the expectation of producing a dramatic reduction in crime may be to invite disappointment. While crime reduction is one result to be hoped for in eliminating drug abuse, its elimination and the treatment of its victims are humane and worthy social objectives in themselves.

PENALTIES

Since early in the century we have built our drug control policies around the twin judgments that drug abuse was an evil to be suppressed and that this could most effectively be done by the application of criminal enforcement and penal sanctions. Since then, one traditional response to an increase in drug abuse has been to increase the penalties for drug offenses. The premise has been that the more certain and severe the punishment, the more it would serve as a deterrent. Typically this response has taken the form of mandatory minimum terms of imprisonment, increasing in severity with repeated offenses, and provisions making the drug offender ineligible for suspension of sentence, probation, and parole.

Federal law was changed twice during the last decade. In 1951, following the post-World War II upsurge in reported addiction, mandatory minimum sentences were introduced for all narcotic and marihuana offenses, 2 years for the first offense, 5 years for the second, and 10 years for third and subsequent offenses. At the same time, suspension of sentence and probation were prohibited for second offenders.[85] In 1956 the mandatory minimum sentences were raised to 5 years for the first and 10 years for the second and subsequent offenses of unlawful sale or importation. They remained at 2, 5, and 10 years for the offense of unlawful possession. Suspension of sentence, probation, and parole were prohibited for all but the first offense of unlawful possession.[86] Many State criminal codes contain comparable, though not identical, penalty provisions.

In support of existing mandatory minimum sentences for narcotics violations, it has been suggested that the high price and low quality of the heroin available on the street and the fact that serious physical dependence on the drug has become a rarity are evidence that there are fewer people willing to face the risk of more severe penalties. On the other hand, with respect to heroin, these trends may have preceded the pattern of mandatory minimum sentence provisions, and enforcement officials have also credited direct enforcement efforts against the international flow of heroin for the changes.[87] And despite the application of such sanctions to marihuana, the use of and traffic in that drug appear to be increasing.[88]

Since the evidence as to the effects of mandatory minimum sentences is inconclusive, the Commission believes that the arguments against such provisions, which appear in chapter 5, are a firmer basis upon which to rest its judgment in this case.

Within any classification of offenses, differences exist in both the circumstances and nature of the illegal conduct and in the offenders. Mandatory provisions deprive judges and correctional authorities of the ability to base their judgments on the seriousness of the violations and the particular characteristics and potential for rehabilitation of the offender.

There is a broad consensus among judges and correctional authorities that discretion should be restored. A 1964 policy statement of the Advisory Council of Judges[89] and repeated testimony by officials of the Bureau of

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[82] The data for 1964 and 1965 were gleaned from the New York City Police Dep't Statistical Report, supra note 80. The 1963 data are from *Hearings on Organized Crime and Illicit Traffic in Narcotics*, supra note 66, at 735 (testimony of Patrick J. McCormack).

[83] The 8% figure is derived from Bureau of Prisons Research and Statistical Branch, Court Commitments to Federal Institutions and Number With a History of Using Drugs, by Fiscal Year and Selected Offenses: Fiscal Years 1956–1965 (unpublished). The source of the 40 percent figure was a staff interview with an official of the New York Dep't of Corrections.

[84] Memorandum prepared by the Federal Bureau of Investigation for the Commission, dated Dec. 21, 1966. A similar FBI memorandum appears in *Hearings on Organized Crime and Illicit Traffic in Narcotics*, supra note 66, at 678.

[85] Act of Nov. 2, 1951, known as the Boggs Act.

[86] The present penalty provisions are contained in INT. REV. CODE OF 1954, § 7237.

[87] See testimony of Harry J. Anslinger, former Commissioner of Narcotics, *Hearings on Illicit Narcotics Traffic Before the Subcommittee on Improvements in the Federal Criminal Code of the Senate Judiciary Committee*, 84th Cong., 1st Sess. 42 (1955); c.f. Lindesmith, supra note 14 at 57.

[88] See Blum, *Dangerous Drugs*. See also *Hearings on S. 2113, S. 2114, S. 2152*, supra note 66, at 185 (statement of John L. Neurauter of Chicago Police Dep't) and 224 (exhibit 46). And see references cited in notes 29–31, supra.

[89] ADVISORY COUNCIL OF JUDGES OF THE NATIONAL COUNCIL ON CRIME AND DELINQUENCY, NARCOTICS LAW VIOLATIONS: A POLICY STATEMENT 15–16 (1964).

Prisons and Board of Parole are expressions of this consensus.[90]

Application of the mandatory minimums has had some measurable results. The first of these has been a substantial increase in the percentage of the Federal prison population serving sentences for narcotic and marihuana offenses. At the close of fiscal 1965 there were 3,998 drug-law violators confined in all Federal institutions. This number represented 17.9 percent of all persons confined. The average sentence being served by the drug-law violators was 87.6 months, and 75.5 percent of them were ineligible for parole. These figures compare with the 2,017 drug-law violators confined at the close of fiscal 1950, comprising 11.2 percent of all persons confined at that time. The 1950 violators were all eligible for parole, and while average sentence data is not available for that year, it would be safe to estimate that sentences averaged much less than one-half of 87.6 months.[91]

Some differential handling of narcotic addicts after conviction is permitted by the civil commitment laws discussed below, which bypass the penalty provisions. Other devices in the present law also permit some distinctions to be made among drug offenders. First offenders charged with unlawful possession under Federal law are eligible for suspended sentence, probation, and parole.[92] Persons under the age of 22 are eligible for indeterminate sentencing under the Federal Youth Corrections Act.[93] Some State laws distinguish mere possession from possession with intent to sell and provide separate penalties for the two offenses.[94] Informal practices also are common, such as reduction of charge by the prosecutor (whose discretion is not circumscribed by the law) to avoid the mandatory minimum sentence provided for the greater offense.[95]

In its recommendations on mandatory minimums, the President's 1963 Advisory Commission sought to avoid the evils of treating all narcotics and marihuana offenders alike by dividing offenses into four groups: [96]

☐ The smuggling or sale of large quanties of narcotics or the possession of large quantities for sale. This would subject the offender to mandatory minimum sentences. Probation, suspension of sentence, and parole would be denied.

☐ The smuggling or sale of small quantities of narcotics, or the possession of small quantities for sale. This would subject the offender to some measure of imprisonment but not to any mandatory minimum terms. Suspension of sentence would not be available but parole would.

☐ The possession of narcotics without intent to sell. The sentencing judge would have full discretion as to these offenses.

☐ All marihuana offenses. The sentencing judge would have full discretion.

This Commission believes that these gradations as to the seriousness of offense are sound in principle. But, for the reasons set forth above and in the discussion in chapter 5 on sentencing, it does not believe they should be rigidified into legislation. Rather, judges and correctional officials should be relied on to take account of the nature of the offense and the record and status of the offender in making their decisions.

The Commission recommends:

State and Federal drug laws should give a large enough measure of discretion to the courts and correctional authorities to enable them to deal flexibly with violators, taking account of the nature and seriousness of the offense, the prior record of the offender and other relevant circumstances.

It should be noted that parole rights have already been reinstated for Federal marihuana violators by a provision of Public Law 89–793.[97]

In submitting the foregoing recommendations, the Commission also wishes to record its concurrence in the view of the Bureau of Narcotics that long terms of imprisonment for major drug violators are essential. The Commission is opposed only to features of existing laws that deny to judges and correctional officials the flexibility to deal with the infinitely varied types of violations and offenders in accordance with facts of each case rather than pursuant to prescribed rigid rules.

MARIHUANA

In addition to suggesting that the penalties provided for narcotics and marihuana offenses be made more flexible, the Commission would like to comment specially on marihuana, because of questions that have been raised concerning the appropriateness of the substantive law applicable to this drug.

The basic Federal control statute, the Marihuana Tax Act, was enacted in 1937 with the stated objectives of making marihuana dealings visible to public scrutiny, raising revenue, and rendering difficult the acquisition of marihuana for nonmedical purposes (the drug has no recognized medical value) and noncommercial use (the plant from which the drug comes has some commercial value in the production of seed and hemp).[98] At the heart of the act are provisions requiring that all persons with a legitimate reason for handling marihuana register and pay an occupational tax, requiring that all marihuana transactions be recorded on official forms provided by the Treasury Department, subjecting transfers to a registered person to a tax of $1 an ounce, and subjecting transfers to an unregistered person to a prohibitive tax of $100 an ounce.[99] Under the Uniform Narcotic Drug Act in force in most States, marihuana is defined and controlled as a narcotic drug.[100]

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[90] *Hearings on Civil Commitment and Treatment of Narcotic Addicts Before Subcommittee No. 2 of the House Judiciary Committee*, 89th Cong., 1st & 2d Sess. 370, 376 (1966) (testimony of Myrl E. Alexander); PROCEEDINGS 255 (statement of James V. Bennett) and 264 (statement of Richard A. Chappell). See also *id.* at 228 (statement of Sen. Thomas J. Dodd), discussing a joint project of the Senate Subcommittee on Juvenile Delinquency and the Subcommittee on National Penitentiaries. In the course of that project, a questionnaire was sent to Federal district judges, Federal chief probation officers, Federal prison authorities, and U.S. Attorneys, inquiring about the effects of the mandatory minimum sentence provisions, and the elimination of probation and parole in the handling of narcotic offenders. Of the Federal prison wardens who responded, 92 percent were opposed to the mandatory minimum sentence provisions, and 97 percent were opposed to the prohibition of probation or parole. Of the responding probation officers, 83 percent were opposed to the first, and 86 percent were opposed to the second. Of the Federal judges who responded, 73 percent were opposed to the first, and 86 percent were opposed to the second. Fifty percent of the responding U.S. Attorneys opposed the first, and 55 percent of them opposed the second. *Ibid.*

[91] The information in this paragraph was derived from unpublished statistical reports prepared by the Research and Statistics Branch of the Bureau of Prisons in 1965 and 1966.

[92] INT. REV. CODE OF 1954, § 7237(d).

[93] 18 U.S.C. §§ 5005–26 (1964).

[94] N.Y. PENAL LAW § 220 (effective Sept. 1967).

[95] *Cf.* ELDRIDGE, op. cit. supra note 79, at 88–89.

[96] PRES.'S ADVISORY COMM'N ON NARCOTIC AND DRUG ABUSE, FINAL REP. 40–42 (1963).

[97] Pub. L. No. 89–793 (Nov. 8, 1966).

[98] S. REP. NO. 900, 75th Cong., 1st Sess. 1 (1937); H.R. REP. NO. 792, 75th Cong., 1st Sess. 1 (1937).

[99] INT. REV. CODE OF 1954, §§ 4741, 4744, 4751, 4753.

[100] UNIFORM NARCOTIC DRUG ACT § 1(14).

The act raises an insignificant amount of revenue[101] and exposes an insignificant number of marihuana transactions to public view, since only a handful of people are registered under the act. It has become, in effect, solely a criminal law imposing sanctions upon persons who sell, acquire, or possess marihuana.

Marihuana was placed under a prohibition scheme of control because of its harmful effects and its claimed association with violent behavior and crime.[102] Another reason now advanced in support of the marihuana regulations is that the drug is a steppingstone or forerunner to the use of addicting drugs, particularly heroin.[103]

The law has come under attack on all counts, and the points made against it deserve a hearing.

THE EFFECTS

Marihuana is equated in law with the opiates, but the abuse characteristics of the two have almost nothing in common. The opiates produce physical dependence. Marihuana does not. A withdrawal sickness appears when use of the opiates is discontinued. No such symptoms are associated with marihuana. The desired dose of opiates tends to increase over time, but this is not true of marihuana. Both can lead to psychic dependence, but so can almost any substance that alters the state of consciousness.[104]

The Medical Society of the County of New York has classified marihuana as a mild hallucinogen,[105] and this is probably as good a description as any, although hallucinations are only one of many effects the drug can produce. It can impair judgment and memory; it can cause anxiety, confusion, or disorientation; and it can induce temporary psychotic episodes in predisposed people. Any hallucinogenic drug, and many of the other dangerous drugs, can do the same. Marihuana is probably less likely to produce these effects than such moderately potent hallucinogens as peyote, mescaline, and hashish (another derivative of the plant from which marihuana comes), and much less likely to do so than the potent hallucinogen LSD.[106]

MARIHUANA, CRIME, AND VIOLENCE

Here differences of opinion are absolute and the claims are beyond reconciliation. One view is that marihuana is a major cause of crime and violence. Another is that marihuana has no association with crime and only a marginal relation to violence.

Proponents of the first view rely in part on reports connecting marihuana users with crime. One such report by the district attorney of New Orleans was referred to in the hearings on the 1937 act.[107] It found that 125 of 450 men convicted of major crimes in 1930 were regular marihuana users. Approximately one-half the murderers (an unstated number) and a fifth of those tried for larceny, robbery, and assault (again an unstated number) were regular users.[108] However, the main reliance is on case files of enforcement agencies. Excerpts from these files have been used to demonstrate a marihuana-crime causal relation.[109] The validity of such a demonstration involves three assumptions which are questioned by opponents of the present law: (1) The defendant was a marihuana user. Usually this can be determined only by the defendant's own statement or by his possession of the drug at the time of arrest. (2) He was under the influence of marihuana when he committed the criminal act. Again a statement, perhaps a self-serving one, is most often the source of the information. Chemical tests of blood, urine, and the like will not detect marihuana.[110] (3) The influence of the marihuana caused the crime in the sense that it would not have been committed otherwise.

Those who hold the opposite view cannot prove their case, either. They can only point to the prevailing lack of evidence. Many have done so. The Medical Society of the County of New York has stated flatly that there is no evidence that marihuana use is associated with crimes of violence in this country.[111] There are many similar statements by other responsible authorities. The 1962 report of the President's Ad Hoc Panel on Drug Abuse found the evidence inadequate to substantiate the reputation of marihuana for inciting people to antisocial acts.[112] The famous Mayor's Committee on Marihuana, appointed by Mayor La Guardia to study the marihuana situation in New York City, did not observe any aggression in subjects to whom marihuana was given.[113] In addition there are several studies of persons who were both confessed marihuana users and convicted criminals, and these reach the conclusion that a positive relation between use and crime cannot be established.[114]

One likely hypothesis is that, given the accepted tendency of marihuana to release inhibitions, the effect of the drug will depend on the individual and the circumstances. It might, but certainly will not necessarily or inevitably, lead to aggressive behavior or crime. The response will depend more on the individual than the drug. This hypothesis is consistent with the evidence that marihuana does not alter the basic personality structure.[115]

MARIHUANA AS A PRELUDE TO ADDICTING DRUGS

The charge that marihuana "leads" to the use of addicting drugs needs to be critically examined. There is evidence that a majority of the heroin users who come to the attention of public authorities have, in fact, had some prior experience with marihuana.[116] But this does not mean that one leads to the other in the sense that marihuana has an intrinsic quality that creates a heroin liability. There are too many marihuana users who do not graduate to heroin, and too many heroin addicts with no known prior marihuana use, to support such a theory. Moreover there is no scientific basis for such a theory. The basic text on pharmacology, Goodman and Gilman, *The Pharmacological Basis of Therapeutics* (Macmillan 1960) states quite explicitly that marihuana habituation does not lead to the use of heroin.[117]

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[101] The revenues attributable to Federal marihuana taxes (occupational tax, transfer tax, and charges for order forms) for the 5 fiscal years 1962-1966 total $418,000. By contrast, the revenues attributable to the Federal narcotic taxes (occupational tax, commodity tax, and charges for order forms) for the same period total $5,813,000. Staff interview with officials in the Reports Div., Internal Revenue Service.

[102] S. REP. NO. 900 supra note 98 at 3; H.R. REP. NO. 792, supra note 98, at 1-2.

[103] See references cited in note 28, supra. See also Bromberg, *Marihuana: A Psychiatric Study*, 113 J.A.M.A. 4 (1939); Reichard, *Some Myths About Marihuana*, 10 Fed. Prob., Oct.-Dec. 1946, p. 15; Murphy, *The Cannabis Habit: A Review of Recent Psychiatric Literature*, 15 Bull. on Narcotics, Jan.-March 1963, p. 15. And see *Hearings on S. 2113, S. 2114, S. 2152*, supra note 66, at 449 (testimony of Henry L. Giordano); Blum, *Dangerous Drugs*.

[104] See references cited in note 103, supra.

[105] New York Medicine, May 5, 1966, pp. 3-4.

[106] See references cited in note 103 supra.

[107] *Hearings on Taxation of Marihuana Before the House Ways and Means Committee*, 75th Cong., 1st Sess. 23-24 (1937).

[108] The New Orleans report has also been mentioned in Bromberg, *Marihuana: A Psychiatric Study*, 113 J.A.M.A. 4 (1939); and Winick, *Marihuana Use by Young People*, in DRUG ADDICTION IN YOUTH (Harms ed. 1965).

[109] See, e.g., ANSLINGER & TOMPKINS, THE TRAFFIC IN NARCOTICS 20-25 (1953); Munch, *Marihuana and Crime*, 18 Bull. on Narcotics, April-June 1966, p. 15.

[110] Murphy, supra note 103, at 15.

[111] New York Medicine, May 5, 1966, p. 3.

[112] PROCEEDINGS 286 (Report of an Ad Hoc Panel on Drug Abuse).

[113] MAYOR'S COMM. ON MARIHUANA, THE MARIHUANA PROBLEM IN THE CITY OF NEW YORK: SOCIOLOGICAL, MEDICAL, PSYCHOLOGICAL AND PHARMACOLOGICAL STUDIES (1944).

[114] See, e.g., Anrade, *The Criminogenic Action of Cannabis (Marihuana) and Narcotics*, 16 Bull. on Narcotics, Oct.-Dec. 1964, p. 23; Bromberg, *Marihuana: A Psychiatric Study* 113 J.A.M.A. 4 (1939); Bromberg, *Marihuana Intoxication*, 91 AM. J. PSYCHIATRY 302 (1934); Bromberg & Rogers, MARIHUANA AND AGGRESSIVE CRIME, 102 AM. J. PSYCHIATRY 825 (1946); Reichard, *Some Myths About Marihuana*, supra note 103, at 17-18; Blum, *Dangerous Drugs*.

[115] Blum, *Dangerous Drugs*.

[116] New York Medicine, May 5, 1966, p. 4. CAL. NARCOTICS REHABILITATION ADVISORY COUNCIL, SECOND ANNUAL REPORT 9 (1966).

The most reasonable hypothesis here is that some people who are predisposed to marihuana are also predisposed to heroin use. It may also be the case that through the use of marihuana a person forms the personal associations that later expose him to heroin.[118]

The amount of literature on marihuana is massive. It runs to several thousand articles in medical journals and other publications. Many of these are in foreign languages and reflect the experience of other countries with the use of the drug and with other substances derived from the hemp plant. The relevance of this material to our own problem has never been determined. Indeed, with the possible exception of the 1944 LaGuardia report, no careful and detailed analysis of the American experience seems to have been attempted. Basic research has been almost nonexistent, probably because the principal active ingredient in marihuana has only recently been isolated and synthesized.[119] Yet the Commission believes that enough information exists to warrant careful study of our present marihuana laws and the propositions on which they are based.

The Commission recommends:

The National Institute of Mental Health should devise and execute a plan of research, to be carried on both on an intramural and extramural basis, covering all aspects of marihuana use.

The research should identify existing gaps in our knowledge of marihuana. A systematic review of the literature will be necessary. The plan should provide for an intensive examination of the important medical and social aspects of marihuana use. It should provide for surveys of the extent of marihuana use and of the nature of such use, i.e., occasional, periodic, or habitual. It should provide for studies of the pharmacology of marihuana and of its immediate and long-term effects. It might also provide for animal studies. The relation of marihuana use to aggressive behavior and crime should certainly be a subject of study. So should the relation between marihuana and the use of other drugs. The Commission of course does not wish to imply that the need for research is confined to marihuana. Much remains to be learned, for example, about the potential uses and dangers of hallucinogenic drugs.

TREATMENT

Until quite recently treatment opportunities for opiate addicts were largely restricted to the two Federal narcotic hospitals at Lexington, Ky., and Fort Worth, Tex. Within the past decade, numerous new programs for the treatment of addiction have been developed. However, there are virtually no programs for the treatment of users of the other dangerous drugs.

LEXINGTON AND FORT WORTH

The Public Health Service hospitals were established, in 1935 and 1938 respectively, for the primary purpose of providing treatment to Federal prisoners who were addicted to narcotic drugs. Voluntary patients, who make up almost one-half the hospital population at any given time, are admitted on a space-available basis after Federal prisoners have been accommodated. Since 1935 there have been more than 80,000 admissions of addict-patients to the two hospitals. The constructed capacity of Lexington is 1,042 beds and of Fort Worth 777 beds.[120]

After withdrawal of the drug and psychiatric evaluation, a wide range of services is available to the patient. These are mainly designed to develop and improve functional skills and to accustom the patient to a stable environment. The recommended length of stay for a voluntary patient is 5 months, but most check out much sooner against medical advice. The hospital authorities are powerless to prevent this.[121]

There is no effective aftercare or supervision in the community, except in the case of a prisoner-patient who is granted parole.[122] The relapse rate is high, but there is growing evidence that it is not as high as the 94-percent rate found in one short-term followup study.[123] Much depends on whether relapse is taken to mean return to drugs once during a period of time or to refer to the drug status of the patient at the end of a period of time.[124] One recent long-term (12-year) followup, using the second method of classification, found that, although 90 of the 100 heroin addicts studied had returned to drug use at some time, 46 of them were drug-free in the community at the time of death or last contact. Among the 30 who were considered to have made the best adjustment, the average length of abstinence was 7 years. Significantly, the best outcomes were found among those who had undergone some form of compulsory supervision after discharge.[125]

THE CALIFORNIA REHABILITATION CENTER

This facility, operated by the California Youth and Adult Corrections Agency, was established in 1961. Most admissions are of addicted misdemeanants and felons convicted in California courts and committed by order of the court.

The program involves a combination of inpatient and outpatient treatment. The addicts are required to remain on inpatient status for at least 6 months, although the average is close to 15 months. During this period they are divided into 60-patient units for purpose of treatment. Work therapy, vocational courses, and a full academic course through high school also are offered.

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[117] Pp. 173–74.

[118] Eddy, Halbach, Isbell & Seevers, *Drug Dependence: Its Significance and Characteristics*, 32 BULL. WLD. HLTH ORG. 721, 729 (1965).

[119] GOODMAN & GILMAN, THE PHARMACOLOGICAL BASIS OF THERAPEUTICS 171 (1960); staff interview with Dr. Roger E. Meyer, Research Psychiatrist, Center for Studies of Narcotics and Drug Abuse, NIMH.

[120] A good account of the operations of the Lexington and Fort Worth hospitals may be found in Maddux, *Hospital Management of the Narcotic Addict*, in NARCOTICS 159 (Wilner & Kassebaum eds. 1965). Dr. Maddux is the former Medical Officer in Charge at Fort Worth. See also *Hearings on S. 2113, S. 2114, S. 2152 Before a Special Subcommittee of the Senate Judiciary Committee*, 89th Cong., 2d Sess. 259 (statement of William H. Stewart, U.S. Surgeon General) and 531 (statement of Robert W. Rasor, Medical Officer in Charge at Lexington) (1966). And see the testimony of Luther Terry, former U.S. Surgeon General, *Hearings on Civil Commitment and Treatment of Narcotic Addicts*, supra note 90, at 118.

[121] See the references cited in note 120, supra.

[122] See the references cited in note 120, supra.

[123] Duvall, Locke & Brill, *Follow-up Study of Narcotic Drug Addicts Five Years After Hospitalization*, 78 PUB. HEALTH REP. 185 (1963); Hunt & Odoroff, *Follow-up Study of Narcotic Drug Addicts After Hospitalization*, 77 id. at 41 (1962).

[124] O'Donnell, *The Relapse Rate in Narcotic Addiction: A Critique of Follow-up Studies*, in NARCOTICS, op. cit. supra note 120, at 226.

[125] See Vaillant, *A Twelve-Year Follow-up of New York Narcotic Addicts: In the Relation of Treatment to Outcome*, 122 *Am. J. Psychiatry* 727 (1966); Vaillant, *A Twelve-Year Follow-up of New York Narcotic Addicts: IV. Some Characteristics and Determinants of Abstinence*, 123 AM. J. PSYCHIATRY 573 (1966); Vaillant & Rasor, *The Role of Compulsory Supervision in the Treatment of Addiction*, 30 Fed. Prob., June 1966, p. 53.

Upon release to outpatient status, the patients are supervised by caseworkers with special training and small caseloads. Patients are chemically tested for the presence of drugs five times a month, both on a regular and a surprise basis, for at least the first 6 months. Failure of the test or other indications of relapse to drugs results in return to the institution. A halfway house, the Parkway Center, provides guidance for those making a marginal adjustment in the community. The patient becomes eligible for final discharge after 3 drug-free years as an outpatient.[126]

The capacity of the Rehabilitation Center is 2,300 patients. Between September 15, 1961, and December 31, 1965, there were 5,300 admissions. During this period 3,243 persons were transferred to outpatient status. Although many were returned to the center, 1,700 persons remained on such status as of December 31, 1965; 27 persons had been finally discharged.[127]

NEW YORK STATE PROGRAM

Between the effective date of the Metcalf-Volker Act, January 1, 1963, and June 30, 1966, there were 6,799 admissions of addicts to treatment units maintained by the State Department of Mental Hygiene. The majority of these were persons who chose treatment in lieu of prosecution for a crime. The treatment units were located in six State hospitals having a total of 555 beds for addict-patients; they could handle over 2,200 addicts a year. Both inpatient and outpatient phases of treatment were provided.[128]

A new and more comprehensive program for the treatment and prevention of addiction is now planned in New York under legislation passed in 1966 and administered by a new agency, the State Narcotic Control Commission. Facilities will be greatly expanded, as indicated by a $75 million appropriation for capital construction. The Commission is authorized, among other things, to conduct basic, clinical, and statistical research; to operate rehabilitation and aftercare centers; and to establish a unified program of education, prevention, care, and community referral.[129]

SYNANON

This is a private antiaddiction soceity founded in 1958. The central location is in Santa Monica, but there are other installations inside and outside California. The organization is made up and managed entirely by ex-addicts, aided by a volunteer medical staff. Membership is voluntary and not always available. The addict who seeks admission must first be screened by a committee. Once admitted, his compulsion to take drugs is countered by "attack" therapy and group pressure. If he does not respond, he can be expelled. If he does, he can move upward to levels of responsibility within the society, perhaps to an executive position. Some members return to the community; others become permanent Synanon residents. As of March 1964, according to its officers, there were 400 drug-free persons affiliated with Synanon.[130]

DAYTOP LODGE

This is a voluntary program serving addicts placed on probation by the local courts in Brooklyn, N.Y. It resembles Synanon in approach, but is supported by a Federal grant and is under court sponsorship. Its capacity, presently 25 addicts, is being expanded.[131]

METHADONE MAINTENANCE

This is an experimental method of treatment for heroin addiction. Its principal sponsors are Drs. Vincent P. Dole and Marie Nyswander. They began their program of research in January 1964, at the Rockefeller University Hospital in New York City. Subsequently treatment units were established at Manhattan General and other New York hospitals. Patients are admitted on a voluntary but selective basis. Motivation and a past record of treatment failures are among the important selection criteria. The patients are free to leave the program at any time. Of the 108 heroin addicts admitted prior to February 1, 1966, 101 were still in the program on that date. The other seven had been dismissed from the program.

The first phase of the treatment involves hospitalization and withdrawal from heroin. The patient is then started on daily doses of methadone, a synthetic opiate that is itself addicting. The daily doses are gradually increased and finally become stable. The median stable dose is 100 milligrams per day. This phase of the program lasts about 5 weeks. It is followed by release to the outpatient phases of the treatment. These involve supportive contacts with the hospital staff and hopefully lead the patient to a secure and responsible position in society. Many of the outpatients are, in fact, employed or in school. No attempt has yet been made to withdraw any outpatient from methadone.

As used in the maintenance program, the methadone is dissolved in fruit juice and taken orally under supervision. It is always dispensed from a hospital pharmacy, and the outpatients are required to return each day for their doses. No prescriptions have been given to patients for the purchase of methadone at drug stores. The patients must also give daily urine samples for analysis.

According to the sponsors of the maintenance program, methadone given in adequate doses blocks the euphoric effects of heroin and does not itself produce euphoria, sedation, or distortion of behavior. The patients allegedly remain alert and functionally normal.

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[126] The information about the California Rehabilitation Center was drawn from the following sources: PROCEEDINGS 101 (statement of Roland W. Wood, Superintendent, California Rehabilitation Center); McGee, *New Approaches to the Control and Treatment of Drug Abusers in California*, in NARCOTICS, op. cit. supra note 120, at 263 (Mr. McGee is Administrator of the California Youth and Adult Correction Agency); *Hearings on S. 2113, S. 2114, S. 2152*, supra note 120, at 11 (statement and testimony of Roland W. Wood); *Hearings on Civil Commitment and Treatment of Narcotic Addicts*, supra note 90, at 355 (statement of Richard A. McGee) and 358 (statement of Roland W. Wood).

[127] See the reference cited in note 126, supra, and CAL. NARCOTICS REHABILITATION ADVISORY COUNCIL, SECOND ANNUAL REPORT (1966).

[128] Meiselas, *The Narcotic Addiction Program of the New York State Department of Mental Hygiene*, in NARCOTICS, op. cit. supra note 120, at 249; Temporary Comm'n on Narcotics Addiction, Report to the Mayor of the City of New York (Nov. 1965); *Hearings on S. 2113, S. 2114, S. 2152*, supra note 120, at 154 (statement of Dr. Donald B. Louria, representing N.Y. Gov. Rockefeller).

[129] N.Y. MENTAL HYGIENE LAW §§ 200–16 (as amended by ch. 192 of the Laws of 1966).

[130] See Yablonsky & Dederich, *Synanon: An Analysis of Some Dimensions of the Social Structure of an Antiaddiction Society*, in NARCOTICS, op. cit. supra note 120, at 193; YABLONSKY, SYNANON: THE TUNNEL BACK (1965).

[131] See Cole, *Report on the Treatment of Drug Addiction*, published as appendix C in this volume. [Hereinafter cited as COLE.] This paper is also a general reference for most points in the treatment section of this chapter.

The question being tested here is whether an opiate drug, regularly administered as part of a medical program, can contribute to the rehabilitation of a heroin addict. The emphasis is on drawing the patient out of the addict community and away from a career of crime and into new social attitudes and relationships. The social rehabilitation of the addict is seen as a more important treatment goal than the medical cure of addiction itself.

The results of the methadone maintenance research are fragmentary. No final judgments about its suitability as treatment or as a public health approach are yet possible.[132]

CYCLAZOCINE TREATMENT

This method involves daily administration of a new drug, cyclazocine, which is a long-acting opiate antagonist and blocks the effects of heroin. The drug is not itself a narcotic. This treatment has been tried, with urinalysis to detect heroin use, on a pilot basis in New York.[133]

PAROLE

Parole is of course not a medical technique, but it may fairly be classified as a form of treatment insofar as it is used to overcome a person's dependence on drugs. Several parole projects, with specially trained staffs carrying small caseloads, are in operation.[134] The theory is that a parole agency, with its authority over the addict, is ideally situated to arrange and coordinate his adjustments in the community. Frequent contact and intensive supervision are necessary. The outpatient phase of the California rehabilitation program mentioned above is a special parole project in method, if not in name. The prototype of such a project, however, was developed in New York.

The 1960 final report of the Special Narcotic Project of the New York State Division of Parole described the results of a study of 344 addict-parolees supervised between 1956 and 1959. Of the total number supervised, 119 offenders had never been declared delinquent, and another 36 had been declared delinquent for reasons not related to drug use. Thus 155, or 45 percent, were found to be abstinent. A followup study of the same project parolees reported that, by the end of 1962, the abstinence rate had fallen to 32 percent. The median length of supervision of the 344 addict-parolees was 15 months in 1962, as against 8 months in 1959.[135] The New York project now operates as the Narcotic Treatment Bureau. As of December 1966, there were 22 parole officers in the Bureau with an average caseload of 30 parolees.[136]

Treatment of narcotic addiction is by no means a certain or perfected medical art. The most remarkable feature of the treatment programs mentioned above, and these represent only a sample, is their diversity of method. Careful and continuing evaluation of these programs, which has often been absent in the past, is imperative. There is great need for better standards for measuring the outcome of treatment. To think only in terms of "cure" is not very meaningful in the case of a chronic illness such as addiction. There is little knowledge about why a good outcome is achieved for one addict but not another, by one method but not another. More trained personnel are desperately needed.[137] Methods of treatment for abusers of nonopiate drugs must be developed, and there is a general need for research effort in the whole area of personality disorder, of which drug abuse is usually a symptom.[138] New facilities will certainly be needed. The $15 million authorized by the Narcotic Addict Rehabilitation Act of 1966 for fiscal 1967 and for fiscal 1968 for grants to State and local governments is a bare minimum.[139] States with drug abuse problems but without specialized treatment programs must initiate such programs. Hospitals and medical schools must devote more attention to drug abuse. This is the beginning of what needs to be done.

Two subjects associated with treatment deserve particular mention. One is civil commitment; the other is the use of drugs in medical practice.

CIVIL COMMITMENT

The enactment of laws authorizing or compelling commitment of drug addicts for purposes of treatment has been the most important development in recent years in the drug abuse field. This trend has broad public acceptance; perhaps it has even assumed the proportions of a movement. In candor it must be said that commitment of addicts began as an experiment, born less out of an established body of medical and scientific knowledge than out of a sense of frustration with orthodox procedures and a demand for new approaches. There was growing awareness that drug addiction was a medical illness and that a clearer distinction, which would make some allowance for the quality of compulsion in addiction, should be made between addicts and other offenders.

California was the first State to initiate new procedures. enacting a Civil Addict Commitment Law in 1961. New York followed with the Metcalf-Volker Act in 1962, but this legislation was revised and broadened in 1966. Also in 1966 a Federal commitment law, the Narcotic Addict Rehabilitation Act, was enacted. These statutes represent the most significant legislation in the field.

The results are still too fragmentary, and experience still too limited, to permit anything more than tentative judgments. A process of trial and error still lies ahead. The Commission therefore considers it imperative that the treatment programs be flexible enough to follow each promising idea and technique as it emerges. Most of all, it is essential that the commitment laws be construed and executed to serve the purpose for which they were intended and by which alone they can be justified. This purpose is treatment in fact and not merely confinement with the pretense of treatment.[140]

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[132] See generally COLE; Dole & Nyswander, *A Medical Treatment for Diacetylmorphine (Heroin) Addiction*, 193 J.A.M.A. 646 (1965); Dole, Nyswander, et al., Methadone Maintenance, A Report of Two Years Experience, presented to the Committee on Problems of Drug Dependence, National Academy of Sciences, National Research Council, Feb. 11, 1966 (cited with the permission of Dr. Dole).

[133] See COLE.

[134] See COLE.

[135] See Diskind, NEW HORIZONS IN THE TREATMENT OF NARCOTIC ADDICTION, 24 Fed. Prob., Dec. 1960, p. 56; Diskind & Klonsky, *A Second Look at the New York State Parole Drug Experiment*, 28 Fed. Prob., Dec. 1964, p. 34.

[136] Letter from Meyer H. Diskind, Dir., Narcotic Treatment Bureau, Dec. 12, 1966.

[137] See COLE.

[138] KOLB, DRUG ADDICTION: A MEDICAL PROBLEM (1962).

[139] Pub. L. No. 89-793, § 402(a) (Nov. 8, 1966).

[140] This is essentially a matter of simple fairness. But see also Rouse v. Cameron, 373 F. 2d 451 (No. 19,863, D.C. Cir. 1966), holding that a person confined to a mental hospital as a result of a verdict of not guilty by reason of insanity may assert a right to treatment in a habeas corpus proceeding, and authorities cited therein for the proposition that due process is denied when a person is deprived of his liberty on the basis of his need for treatment but is not provided such treatment.

THE TYPES OF CIVIL COMMITMENT

The expression "civil commitment" is misleading. The fact is that these commitments usually take place at some point during a criminal proceeding. They are denominated "civil" because they suspend that criminal proceeding and because they do not result in penal confinement.

Civil commitment is generally understood to mean court-ordered confinement in a special treatment facility, followed by release to outpatient status under supervision in the community, with provision for final discharge if the patient abstains from drugs and for return to confinement if he relapses. The total commitment is for an indeterminate period not to exceed a prescribed maximum term. The confinement phase usually entails withdrawal of drugs and therapy designed to overcome psychic dependence. The outpatient phase generally includes a variety of supportive services plus some form of periodic testing for the use of drugs.

At least four types of civil commitment can be identified:

1. Commitment on request of noncriminal addicts, i.e., those who are neither charged with crime nor under sentence after conviction of crime. Both State laws and the Federal law offer this with the proviso that the addict must subject himself to a prescribed maximum term.
2. Involuntary commitment of noncriminal addicts. There is provision for this type in the California law (it has produced only a small minority of the admissions since 1961), the recent New York law, and the Federal law. Under each, the addict is entitled to a jury trial on the issue of addiction.
3. Commitment on request or consent of criminal addicts, i.e., those charged with crime but not yet convicted and those who have been both charged and convicted. The New York and Federal laws provide for this type during the preconviction stage of the proceeding only. The California law does not provide for it at all.
4. Involuntary commitment of criminal addicts. All three laws contain provision for involuntary postconviction commitment. None contains provision for involuntary preconviction commitment.[141]

THE ARGUMENTS PRO AND CON

The involuntary commitment of noncriminal addicts and the voluntary commitment of criminal addicts are controversial and raise difficult issues.

The most heated debate centers on the involuntary commitment of the addict who is not accused of crime. Its proponents compare it to the practices of involuntarily committing the mentally ill, or isolating persons with serious contagious diseases; they argue that the addict is both a health risk to himself and a crime risk to others; they point to the evidence that addiction is spread by social contact with addicts rather than by the recruiting efforts of peddlers. These premises, buttressed by the right of a State to protect the general health and welfare of its citizens, lead them to the conclusion that commitment for treatment offers the maximum benefit to the individual and the minimum risk to society. Its opponents dispute both the premises and the conclusions. They contend that at the very least there should be a specific finding that the person to be committed is reasonably likely to commit dangerous acts; that mere proof of addiction is not a sufficient showing that a person is dangerous to himself or others; and that, in any event, the commitment is a subterfuge—it holds out the promise of a known method of treatment, or a reasonable prospect of cure, which does not exist.[142]

These questions are not easily resolved. However, the Commission believes that involuntary civil commitment offers sufficient promise to warrant a fair test. But it must not become the civil equivalent of imprisonment. The programs must offer the best possible treatment, including new techniques as they become available, and the duration of the commitment, either within or outside an institution, must be no longer than is reasonably necessary.

Another group of issues is raised by voluntary commitment to treatment, before conviction, of addicts charged with crimes. The claimed advantages of such a commitment are that the addict can receive immediate treatment and avoid the stigma of criminal conviction. The eligible addict is given the choice of proceeding to trial or being committed. If he elects commitment, the criminal case is suspended pending the completion of treatment.

The objection in principle to this form of commitment is that a defendant, even though mentally competent in a legal sense, can avoid trial simply by asserting the fact of his addiction in a preliminary proceeding. Thus, so contend the critics, the ultimate issue of guilt or innocence is never reached at all.[143]

In practice there are further objections. These relate to:

☐ The period of time within which the addict must exercise his election to undergo treatment. Under the Federal commitment law, the eligible addict must act within 5 days of being advised by the court of his right to elect. Thus the opportunity to consult with counsel is doubtful, and coercion to forego valid defenses is possible.[144]

☐ The inflexible term of commitment. Under both the Federal and the New York laws, the term of commitment is for a period not to exceed 3 years. A person facing a charge carrying an average or expected sentence in excess of 3 years would probably be induced to elect treatment, whereas a person having the same or greater need for treatment, but facing a shorter sentence, would probably elect a trial. Thus the worst offenders would be channeled into the commitment program.[145]

☐ The fact that a mere showing of addiction is sufficient basis for commitment. No existing law makes it a condition of commitment that a relation between the addiction and crime charged be shown. The addict is not even required to establish that his addiction existed at the time of the alleged crime. Thus an addict may be relieved of his obligation to answer a criminal charge, even though his addiction was entirely unrelated to that charge.[146]

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[141] Aronowitz, published as appendix D in this volume, *Civil Commitment of Narcotic Addicts and Sentencing for Narcotic Drug Offenses* (report to the Commission, published in appendix), hereinafter cited as ARONOWITZ.

[142] ARONOWITZ. See also CHEIN, THE ROAD TO H 332–34 (1964).

[143] See, e.g., H.R. REP. NO. 1486, 89th Cong. 2d Sess. 52–53 (1966) (statement of minority views); see also ARONOWITZ.

[144] See *Aronowitz*.

[145] See *Aronowitz*.

☐ The provisions that exclude certain addicts from treatment. The Federal act, for example, makes all of the following classes of addicts ineligible for commitment to treatment before conviction: Those charged with crimes of violence; those charged with unlawfully importing or selling a narcotic drug; those against whom a prior felony charge is pending; those with two or more felony convictions; and those who have been civilly committed because of narcotic addiction on three or more occasions. Some of these exclusions do not appear advisable. Addicts charged with sale of drugs should be eligible for treatment if the primary purpose of sale was to support their addiction. Likewise two prior felony convictions seem an arbitrary basis for exclusion, especially since prior drug felonies are counted. Finally, a history of past treatment failure is not a valid reason to exclude an addict from present treatment. Addiction is a long process and relapse is predictable. Limited treatment goals are the only realistic ones, and the vital question to ask in measuring success is not whether the addict has completely abstained but whether he has improved in the sense of being less dependent on drugs or using them less frequently. The fact of prior relapse says little about present treatment prospects. The Commission believes that, where laws exist permitting voluntary commitment of addicts who have been charged with but not convicted of crime, judges should have broad discretion to admit addicts to treatment. Only those who are dangerous or habitual criminals aside from their addiction should be excluded.[147]

MEDICAL PRACTICE AND ADDICTION

What limits does the law set on the right of a physician to prescribe or administer narcotic drugs to a narcotic addict? This short question raises issues that have been warmly debated for a long time [148]—issues that are not resolved by reference to the general proposition that the statutory and regulatory measures for the control of narcotic drugs are not intended to interfere with the administration of such drugs in legitimate medical practice. The important issues are: How and by whom is the concept of legitimate medical practice defined and given content? Does legitimate medical practice mean the same thing as that practice accepted and followed by a majority of doctors in the community or as that approved by official spokesmen of the medical profession? If so, and if adverse legal consequences attend any departure from legitimate medical practice, how can new medical ideas and techniques safely be developed? What allowance is made for the good faith of a doctor who departs from standard treatment procedures while acting in what he considers to be the best interests of his patient?

Some background is necessary to put these issues into perspective. The Harrison Narcotic Act of 1914 regulates the distribution of narcotics. It requires those whose usual business involves transactions in narcotic drugs (including physicians) to register and pay an occupational tax, and it imposes a commodity tax evidenced by stamps, on all narcotics manufactured.[149] It further requires that all narcotics be distributed and transferred in original stamped packages, pursuant to order forms provided by the Treasury Department.[150] Failure to comply with these provisions is a criminal offense. Specifically exempted from the operations of the act, however, are prescriptions issued by a physician "for legitimate medical uses" and distribution of drugs to a patient "in the course of his professional practice only." [151] The very obvious but very important point to note here is that the medical practice exemption is part of a criminal statute. A prescription of drugs that falls outside this exemption is much more than a professional mistake on the part of a doctor. It is a prosecutable offense.

The American Medical Association has adopted and issued several statements on the use of narcotics in medical practice.[152] The most recent, which appeared in 1963, and is currently in the process of revision, was prepared in collaboration with the National Research Council of the National Academy of Sciences. It may be summarized as follows:

☐ Continued administration of drugs for the maintenance of addition is not a bona fied attempt at cure. In other words withdrawal of the drug must be accomplished before the rehabilitation phase of the treatment can begin.

☐ Withdrawal is most easily carried out in a drug-free environment, in specialized wards or installations for narcotic addicts. Under certain circumstances withdrawal may be carried out in other institutional settings, such as psychiatric wards of general hospitals.

☐ Withdrawal on an ambulatory basis (outside an institution) is, as a general matter, medically unsound and not recommended on the basis of present knowledge.

☐ Ambulatory clinic plans (dispensing drugs to outpatient addicts through clinics established for that purpose) or any other form of ambulatory maintenance (giving stable doses to outpatient addicts) are also medically unsound on the basis of present knowledge.

☐ It is proper ethical practice, after consultation and subject to keeping adequate records, to administer narcotics over a prolonged period to patients with chronic incurable and painful conditions, when reasonable alternate procedures have failed, or to maintain an aged or infirm addict, when withdrawal would be dangerous to life. Finally it is ethical to administer maintenance doses generally of methadone, a synthetic narcotic, to an addict who is awaiting admission to a narcotic facility, and to administer limited and diminishing doses to an addict during a process of withdrawal.

☐ Research on the problems of narcotics addiction is absolutely necessary and present concepts are open to revision based on the results of such research.

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[146] The Federal law was criticized on this ground by the Judicial Conference of the United States. See *Hearings on Civil Commitment and Treatment of Narcotic Addicts Before Subcommittee No. 2 of the House Judiciary Committee*, 89th Cong., 1st & 2d Sess. 465 (1966) (letter from William E. Foley, Dep. Dir., Administrative Office of the U.S. Courts).

[147] See *Aronowitz*. See also *Hearings on Civil Commitment and Treatment of Narcotic Addicts*, supra note 146, at 357 (statement of Richard McGee).

[148] See, e.g., King, *The Narcotics Bureau and the Harrison Act: Jailing the Healers and the Sick*, 62 YALE L.J. 736 (1953); LINDESMITH, THE ADDICT AND THE LAW 3-25 (1965).

[149] INT. REV. CODE OF 1954, §§ 4701, 4703, 4722.

[150] INT. REV. CODE OF 1954, § 4705(a).

[151] INT. REV. CODE OF 1954, §§ 4704(b)(1), 4705(c)(1).

[152] AMA, NARCOTICS ADDICTION: OFFICIAL ACTIONS OF THE AMERICAN MEDICAL ASSOCIATION 51 (1963).

The AMA–NRC statement touches on areas of active controversy—maintenance, clinic plans, and ambulatory treatment. The Bureau of Narcotics accepts it as the authoritative definition of legitimate medical practice against which all medical practice is to be measured. However, there is a small but vocal minority, composed of reputable men within the medical profession, who do not consider it either authoritative or complete. At least some of these men do not regard withdrawal of the addict from drugs as the first, perhaps not even as the ultimate, treatment objective. Some would permit addicts to continue on stable doses of narcotics, either by means of a clinic arrangement or in some other medical setting.

The Commission has no doubt that the AMA–NRC 1963 statement was an accurate expression of the consensus of medical opinion about treatment. It has been given the explicit approval of the Bureau of Narcotics in a widely distributed pamphlet.[153] Whatever the situation might have been before 1963, there is now no reason for any confusion or apprehension on the part of physicians about their legal right to treat addict-patients in most circumstances that are likely to arise.

One dilemma remains. It is equally felt by the medical profession and by agencies charged with enforcement of narcotic statutes. That dilemma is: What action is to be taken in regard to the physician who departs, or is suspected of having departed, from the AMA–NRC standards concerning the dispensing and prescription of narcotic drugs? Such a physician might have acted without the pretense of treatment, or a bona fide physician-patient relationship, in which case he would clearly have violated the law. But he might also have acted in complete good faith following what he considered to be the best course of treatment for his patient. Should he then be subject to a criminal investigation? One visit from an agent of the Bureau of Narcotics might well be enough to cause him to discontinue his method of practice. It might also deter other physicians and discourage new treatment ideas and approaches.

While the AMA–NRC statement leaves room for research looking to the revision of present treatment concepts, the Commission does not believe that this alone provides sufficient guidance. Who is to know where research begins and ends? How many patients may be involved and for how long? Can techniques that have been tried before, and perhaps failed, be tried again? Who is to judge the qualifications of the researcher and the controls built into the program? These plainly do not seem appropriate questions for enforcement agencies, and yet the answers may determine whether there has been a violation of the laws that those agencies enforce.

The Commission believes that the ultimate resolution of these problems depends on closer cooperation and liaison between the medical profession and law enforcement. Some new measures of cooperation are already in effect. In 1965, for example, a national body was formed for the purposes of keeping current the standards of ethical medical practice with relation to narcotics and narcotic addicts and acting in an advisory capacity to the Bureau of Narcotics. This body is composed of the membership of the Committee on Problems of Drug Dependence, National Academy of Sciences-National Research Council, and of the Committee on Alcoholism and Drug Addiction, American Medical Association Council on Mental Health, meeting jointly. There must be frequent contacts between this body and the Bureau. In accordance with the AMA–NRC 1963 recommendation, responsible medical bodies should also be established in each State to collaborate in the investigation of physicians under question concerning alleged irregularities in prescribing or dispensing narcotics. Questions concerning the proper limits of medical research could also be referred to these bodies. The Commission further believes that, as recommended by the President's Advisory Commission on Narcotic and Drug Abuse in 1963,[154] consideration should be given to clarification of the Bureau of Narcotics regulation which states that a prescription for narcotics "not in the course of professional treatment but for the purpose of providing the user with narcotics sufficient to keep him comfortable by maintaining his customary use" is an unlawful act subject to the penalties of the Federal narcotics laws.[155] This regulation is ambiguous, makes no allowance for research, and has caused much unnecessary misunderstanding.

The inescapable fact is that medical science has not come very far or very fast in this extremely puzzling field. The need for expanded research is fundamental. It is in the interest of both the medical profession and good law enforcement that no obstacles be put in the way of such research.

EDUCATION

In 1963 the President's Advisory Commission on Narcotic and Drug Abuse found that public and professional education in the field was inadequate. It found the problem clouded by misconceptions and distorted by persistent fallacies.[156] Unfortunately these conclusions are as valid today as they were 3 years ago. Misinformation about drugs and their effects is still prevalent, and the measures taken by the Federal Government to correct them are still limited, fragmented, and sporadic. The National Clearinghouse for Mental Health Information within the National Institute of Mental Health (NIMH) collects and disseminates information, but drug abuse is only one of its many concerns, and its audience is largely made up of researchers and other specialists. Similarly, the educational efforts of the Bureau of Narcotics and the Bureau of Drug Abuse Control, while well intended and well executed, are not on the necessary scale. There is a clear present need for a single agency, having a specific mandate for education, to prepare and distribute a broad range of materials, from pamphlets to films, suitable for presentation to target segments of the public, such as college students. The materials must above all be factual.

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[153] U.S. TREASURY DEP'T, BUREAU OF NARCOTICS, PRESCRIBING AND DISPENSING OF NARCOTICS UNDER HARRISON NARCOTIC LAW, Pamphlet No. 56 (1963).

[154] PRES.'S ADVISORY COMM'N ON NARCOTIC AND DRUG ABUSE, FINAL REP. 56–57 (1963). Contra, *Hearings on Organised Crime and Illicit Traffic in Narcotics Before the Permanent Subcommittee on Investigations of the Senate Government Operations Committee*, 88th Cong., 1st & 2d Sess., pt. 3, at 814 (1964) (Brief of Court Decisions Bearing Upon the Meaning of the Term "Professional Treatment," Used in Section 151.392, Title 26, Code of Federal Regulations).

[155] Treas. Reg. 151.392.

[156] PRES.'S ADVISORY COMM'N ON NARCOTIC AND DRUG ABUSE, FINAL REP. 21–30 (1963).

The Commission recommends:

A core of educational and informational materials should be developed by the National Institute of Mental Health.

This same recommendation was made by the 1963 Commission.[157] Since that time a Center for Studies on Narcotics and Drug Abuse has been established within NIMH. This unit might be the appropriate one to charge with the major Federal responsibility for education. Wherever the responsibility is placed, it should be discharged with the cooperation of other Federal agencies, State and local agencies, universities, and private organizations. Adequate staff and funding should be provided on a priority basis.

The urgent need for a Federal response in education produced at least one hopeful start in 1966. A program to increase understanding of drug problems on college campuses has been undertaken by the National Association of Student Personnel Administrators under a contract with the Bureau of Drug Abuse Control. Regional seminars will be held for the benefit of campus officials. Written materials will be prepared and disseminated, and methods of communicating effectively with students will be explored. This is a useful, but only a very preliminary step. It is aimed at college students only. Moreover the work will end when the contract expires in 1967. The Federal responsibility for education will not expire at the same time.

The Commission believes that the educational function must be given continuing and central direction by a single agency.

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[157] Id. at 19.

MIND-ALTERING DRUGS AND DANGEROUS BEHAVIOR: DANGEROUS DRUGS

by Richard H. Blum, assisted by Mary Lou Funkhouser-Balbaky

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INTRODUCTION

It is the purpose of this report to present, in a preliminary fashion, the available facts about the relationship of certain mind-altering drugs to dangerous behavior, specifically to crimes, to vehicle accidents, and to suicide. It is also the purpose of this report to evaluate the data at hand and to make preliminary recommendations.

Our full report consists of several different papers, one on narcotics (opiates, synthetic opiates, and cocaine), one on alcohol, the present document which encompasses marihuana, hallucinogens, amphetamines, tranquilizers, barbiturates, and the volatile intoxicants, and one paper on drugs and social policy.[1] There is an introduction only to the present document, consequently for the reader interested in all of the papers, it is best to read this introduction and the accompanying paper first and to read the social policy paper last.

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The collection of papers which constitute the full report suffers a number of limitations some of which must be made explicit. Only a small budget was allocated for the work so that it has been necessary to restrict the literature review to published reports, most of these in English. Only 4 months were available for the preparation of all four papers; the deadlines for the work of the Commission being so critical that no further time could be allocated. None of the work was done on a full-time basis since neither the funds available nor the other obligations of the authors allowed a full-time effort. In consequence it must be recognized that the literature survey may be incomplete, and that supplemental unpublished data could not be incorporated. It will also be found that there is overlap between the papers with reference to discussion of fundamental issues. Part of that overlap can be attributed to the fact that at the time of the writing of the present document (perhaps best referred to as the "dangerous drugs" paper in spite of the inapplicability of that term—in regard to legal status—to marihuana and the volatile intoxicants), it was not known that the narcotics, alcohol, and social policy papers were to be prepared.

SCOPE OF THE FULL REPORT

Our task has been to concentrate on those drugs whose primary effects are mind altering and behavior changing—that is, they ordinarily affect moods, states of consciousness, levels of feeling and arousal and subsequent conduct. Sometimes called psychoactive or psychotropic drugs, these substances include preparations classified as opiates, stimulants, sedatives, intoxicants, tranquilizers, antidepressants, and hallucinogens. Among these the term "narcotic" is most often applied to opium, its derivatives and synthetic analogs. Among intoxicants may be included alcohol, the volatile intoxicants such as some glues, gasoline, paint thinners, ether, etc., and, in another class, cannabis-derived preparations such as marihuana. As we shall shortly note, all classifications of drugs based on presumed behavior outcomes or on legal status are inadequate and confusing. Suffice it to note that ether is also an anesthetic, marihuana a narcotic or an hallucinogen, and alcohol a stimulant, depressant, or tranquilizer depending upon the circumstances of the discussion.

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[1] The papers on narcotics and on drugs and social policy also appear in this volume, as appendix A-2 and appendix A-3. The paper on alcohol appears in the Task Force Report on Drunkenness as appendix B.

In our report we have excluded a number of substances which do affect consciousness and conduct. We have not discussed drugs which are used primarily in the medical treatment of physical illnesses but which may also have mind-altering side effects—cortisone and belladonna are examples. Some persons now use these substances for psychological rather than medical purposes. We have also excluded ordinary spices, foods and beverages which some persons can employ for mind-altering effects; nutmeg is an example. Finally, we have not attended to the mild stimulants such as caffeine (coffee, tea, some soft drinks), theobromine (from cacao beans and kola nuts, found in cocoa, chocolate, cola drinks), the mild pain killers (aspirin, etc.), and tobacco.

Our review has not focused on the outcomes of drug use that are primarily medical, that is, biochemical, physiological or anatomical; rather we have concentrated on human behavior associated with drug use. In attending to behavior, it has been necessary to consider a wide range of human activity associated with drug use but, for reporting purposes, we have restricted ourselves to behavior designated as criminal, suicidal, or associated with vehicle accidents (or industrial and other accidents when data is available).

We have been interested in several different kinds of data. We have sought "hard" experimental data which shows causal relationships between drug ingestion (under given dosage, routes of administration, settings, and kinds of persons) and dangerous behavior. We have been interested in data showing or suggesting correlations between several kinds of behavior, some of which involves drug use and some of which is dangerous, but where no causal links are demonstrated. We have been interested in clinical reports which observe individual reactions associated with drug ingestion or use overtime but where there have been no systematic scientific controls made in the observation. We have also been interested in popular beliefs, in the claims made by writers, witnesses and pressure groups, and in the opinions expressed by advocates of various kinds of drug distributing or drug controlling positions.

SOURCES REVIEWED

In our work to date we have reviewed the following reference sources: The abstract library of the Psychopharmacology Project at Stanford (consisting of some 1,600 article reviews derived from continuing scientific literature surveys, "Psychopharmacology Abstracts," "Psychological Abstracts," "Int. Bibliography on Crime and Delinquency," "Current Projects: Crime and Delinquency," "Readers Guide to Periodical Literature," "Excerpta Criminologica," "The Question of Cannabis," "A Bibliography" (U.N. Commission on Narcotic Drugs, 1965), "Smith, Kline, and French Drug Abuse Bibliography," "Drug Addiction," "A Bibliography" (Tompkins, D.C., 1960), and the "Classified Abstract Archives of the Alcohol Literature." We have also referred to other bibliographical compilations, to references in primary sources, and have, of course, read all the primary sources available. In addition, we have addressed inquiries to several dozens of investigators, institutions, and agencies interested in dangerous behavior and drug use and met with as many workers in the field as possible.

SUMMARY OF CURRENT KNOWLEDGE

It is best to begin with a few general statements designed to put drug use and drug effects in perspective. In the first place, it is clear that our interest should be not in what drugs as such do, but rather in what people do after they take drugs. Drugs may modify behavior but they do not create it. Our focus must remain on the persons taking drugs rather than on the pharmaceuticals alone. The second fact to bear in mind is that no mind-altering drug, taken with the range of dosage that allows the person taking the drug any choice of actions (when the dosage becomes so great that choice behavior is eliminated, the outcome is then usually stupor, coma, shock, psychosis or death), ever has a single uniformly predictable behavior outcome. The general classifications used for these drugs, for example "sedatives" or "stimulants" are misleading; these only describe probable outcomes for certain persons under certain conditions. Within normal dosage ranges there will be among a group of persons or even for the same person on different occasions a variety of behavior outcomes. These outcomes will be partly and sometimes largely determined by factors other than the pharmaceutical substance itself, for example by the person's expectations of what the drug should do, his current moods and motives, the social setting in which the drug is used, the tasks he is performing and so forth. Consequently one must be careful not to assume that the popular terminology employed for classes of drugs is an accurate description of their effect. For example, LSD is called a "hallucinogen" but the research to date shows that hallucinations are one of the infrequent experiences reported by persons taking LSD. Marihuana is classified as a "narcotic" under some laws; nevertheless, it seems more likely to produce intoxicating effects similar to alcohol. Because of the great variability in behavior under drugs it is also necessary to keep in mind that there can be considerable overlap among drug classes in terms of outcomes or, put differently, different kinds of drugs can produce similar behavior, for example an intoxicant (alcohol, marihuana), a sedative, and a tranquilizer may all appear to produce sleep in one subject under one circumstance (for example, at bedtime); these same drugs given to the same subject in a different setting (for example, a party) may all appear to produce stimulation.

A third general consideration is that the drugs under consideration in this report are commonly used outside of medical channels even when the law may stipulate, as in "dangerous drug" statutes, that use is to be limited to medically supervised circumstances. Their use may be "social" in the sense that the drugs are taken by people when they are together or "private" in that they are taken when a person is alone. The presumption is often made that nonmedical use implies both pleasure and risk and so it is that such drugs may be termed "pleasure-producing" or "euphoria-producing" drugs as well as being considered dangerous or illicit. It may also popularly be believed that the medical use of such substances is therapeutic and therefore not pleasurable and also that in medical use there is no social risk. It must be recognized that the foregoing are all assumptions and not facts. On the basis of available evidence it seems clear that the implication of "pleasure" is not a satisfactory explanation for much social and private (nonmedical) drug use, that the definition of some of these substances as "dangerous" in the social sense (crime, accidents, suicide) rests on very shaky grounds as opposed to clinical and medical dangers which are for the most part better documented, and that, in turn, the medically supervised use of drugs does not exclude social risks (crime, accidents, and suicide).

As a fourth consideration it is to be noted that all of the drugs considered here have been described, by one or another source, as potentially "addicting" or "habit forming." Under the new terminology recommended by the World Health Organization the word "addiction" is to be dropped in favor of "dependency." In any event these drugs are described as substances to which persons become habituated so that they use them often and perhaps in increasing amounts and may, upon withdrawal, experience some form of distress. It is important to realize that although the probabilities of withdrawal symptoms (for example, pain, nausea, acute anxiety) as such do vary depending upon the drug's physiological effects, dependency potential itself seems very much to be linked to persons as much as to drugs. As yet not completely understood sociopsychological (and perhaps physiological and genetic) factors seem to predispose persons to become drug dependent; it is possible that the particular drug or groups of drugs (multihabituation) upon which they become dependent is incidental. In considering the behavioral consequences of drug use it is well to realize that habituation can exist without there being concomitant criminality. Whether habituation can exist without an increased risk of death or accidents remains to be established. Insofar as the use of a drug is itself illicit then there can be no drug use without criminality; if however one attends to crimes against person or property as opposed simply to the violation of law occurring because a drug is used, then the best evidence to date suggests that the drug-crime relationship depends upon the kinds of persons who choose to use drugs, the kinds of persons one meets as a drug user, and on the life circumstances both before drug use and those developing afterward by virtue of the individual's own (e.g., dependent or addictive) response and society's response to him (prohibition of use, arrest, and incarceration, etc.). In spite of popular beliefs to the contrary, one dare not assume that drug-dependency *qua* dependency leads inevitably to any particular type of social conduct, including criminality. Insofar as some activities are part of obtaining and using the drugs themselves, these will be repeated but these activities may or may not be criminal depending, as we have noted, on the laws and social circumstance of the person.

There is another fact to consider as part of the evaluation of drug use, drug abuse, and dangerous outcomes. Mind-altering drug use is common to mankind. Such drugs have been employed for millennia in almost all cultures. In our own work we have been able to identify only a few societies in the world today where no mind-altering drugs are used; these are small and isolated cultures. Our own society puts great stress on mind-altering drugs as desirable products which are used in many acceptable ways (under medical supervision, as part of family home remedies, in self-medication, in social use [alcohol, tea parties, coffee klatches, etc.] and in private use [cigarettes, etc.]). In terms of drug use the rarest or most abnormal form of behavior is not to take any mind-altering drugs at all. Most adult Americans are users of drugs, many are frequent users of a wide variety of them. If one is to use the term "drug user" it applies to nearly all of us. Given this fact, the frequently expressed concern about drug "use" might better be put in terms of drug "abuse." "Abuse" of course is also ill defined. Presumably judgments of abuse rest on such questions as (*a*) How much of the drug, or drug combinations, is taken and how is intake distributed? (*b*) Does the person take disapproved drugs? (for example, heroin instead of alcohol, marihuana instead of tranquilizers), (*c*) Does he take drugs in unapproved settings? (an adolescent drinking wine with a gang rather than at the family dinner table, an adult taking amphetamines without medical approval), (*d*) Does his behavior under drugs offer some real risk to himself or to others? (Our primary concern here: Crime, accidents, suicide, but also dependency, medical danger, etc.) There are, no doubt, other factors that would be revealed should one do a study of how people come to judge that drug "abuse" is occurring. The critical point for us is the realization that "use," "abuse," and "risk" are emotionally charged terms that may be based on hidden determinants or open assumptions that cannot be shown to have a factual basis.

To offer one conclusion at the outset, it is that current evaluations of drug use by the public, by the mass media, and by some officials, are often emotional. The programs, laws, and recommendations that arise from these emotional responses may well be inappropriate if the steps taken do not match drug use realities. What those "realities" might be is most uncertain, for at the present time we know little about the extent of the use of any of the mind-altering drugs, about the characteristics of those using one or another "dangerous drug" (excluding alcohol and opiates), or about the kinds and frequencies of risks as a function of dosage, frequency, setting, and kinds of persons using any of these drugs. Consequently, we do not presently have enough knowledge at hand about persons, about conduct, about drugs per se, or about the effects of one or another programs of control or cure to make any recommendations for prevention, control, or cure where there can be certainty about the results even if those recommendations were to be fully implemented. The fact pervades policymaking with reference to mind-altering drugs.

MARIHUANA

DISTRIBUTION

Nearly worldwide in both production and use.

EXTENT OF USE IN THE UNITED STATES

Only limited epidemiological data available. A few sociological studies of special using groups (musicians, professional people, slum Negroes, students.) Police statistics are an inadequate source of data because of apparent concentration of arrests in lower class groups and because marihuana arrests may be combined statistically with heroin and opium arrests. There is no current way of assessing the relationship of cases known to the authorities to actual prevalence of use in the population. Furthermore, fashions in drug use appear to be changing rapidly so that earlier data is likely to be inaccurate. One recent pilot study (Blum, Braunstein, and Stone, 1965, unpublished)[2] in two west coast metropolitan communities, the sample size too small to allow any assumption of accuracy of estimate, reported 9 percent of the adult population had tried marihuana and 2 percent were using it either occasionally or regularly. In one west coast university, a university health officer (Powelson, 1966) (Corry, 1966) estimated 20 percent of the students were using marihuana; the police department (Berkeley Police Department, 1966) estimated only 1 percent use. Another unpublished student study (121 students in a west coast college) reported 11 percent experienced but none as regular users (Med. Soc. of New York, 1966). Great Britain (Anon., 1964) reports sixfold increase in hashish smuggling from 1963 to 1964 and other British reports suggest, as do impressionistic United States reports, a continuing increase in use.

CHARACTERISTICS OF USERS

There are no epidemiological or "drug census" studies for the Nation as a whole. Descriptions made in the 1930's and 1940's found use was predominantly among minority group members and economically depressed urban youth, especially those judged as having inadequate personalities. Studies in Asia and Africa (Asuni, 1964; Chopra, 1939; Lambo, 1965; Watt, 1936) suggest use is concentrated among the young, urban poor and is associated with dissatisfaction, deprivation, and mobility. In India upper class and "respectable" use occurs (Chopra). In the United States the impression, not supported by adequate studies, is that use ranges from young urban poor, including minorities, to disaffected "beatniks" through artistic and university communities to younger professional persons in metropolitan centers. Use appears to be concentrated in the 18 to 30 age group but reports of both downward (high school) and upward (over 30) diffusion are appearing. The best estimate is that experimentation is far more common than regular use and that heavy use (as occurs in Africa and Asia) is quite rare.

REPORTED RISKS

Some law enforcement officials and Federal Bureau of Narcotics personnel have held that marihuana leads to (*a*) criminal acts associated with impulsivity, recklessness, and violence, (*b*) distasteful behavior associated with disregard for cleanliness, unrestrained sexuality, rebelliousness, unpredictable relations with others, (*c*) risk of later heroin dependency because marihuana use creates interest in having drugs experiences which marihuana cannot produce and because it is obtained through illicit channels which also provide opportunities for access to heroin (and cocaine). Also reported (Watt; Asuni; Chopra; Murphy, 1963; Wendt, 1954) as risks are cannabis psychoses, cannabis dependency, decrements in work performance, and traffic accidents due to poor judgment and attention.

VERIFIED RISKS

Studies in India (Chopra) and North Africa (Asuni; Lambo) show that cannabis psychoses occur in association with heavy use of potent forms of cannabis. Dependency is also described, as is apathy, reduced work, and social effectiveness, etc. These effects may be due, in some measure, to the vulnerability of the using population (already hopeless, sick, hungry, etc.). In the United States neither cannabis psychosis nor cannabis dependency has been described, although marihuana may be one of a variety of drugs used in the multihabituation (Cohen and Ditman, 1962) pattern, where a person takes many different drugs and appears dependent, but not on any one of them. Case history material suggests that many identified heroin users have had earlier experiences with marihuana, but their "natural history" is also likely to include even earlier illicit use of cigarettes and alcohol. The evidence from our college students and utopiate and news articles is clear that many persons not in heroin-risk neighborhoods who experiment with marihuana do not "progress" to "hard" narcotics.

With regard to crime, other than the violation of law occurring by virtue of acquiring and possessing marihuana, there is no reliable evidence that marihuana "causes" crime. One Brazilian study (Andrade, *Bull. of Narcotics*, 1964) observed 120 marihuana-using criminals and concluded their criminal actions were not a result of their drug use. A Nigerian study (Asuni) suggests that those who are at risk of hashish use are also at risk of criminality because of their primary social and psychological characteristics (being members of frustrated underprivileged groups living in urban areas with opportunities for committing crimes). In Nigerian hospitals with patients with histories of cannabis psychosis or use, there was no relationship of use to crime. In Indian studies (Chopra) a negative relationship has been suggested, for with heavy cannabis use stupor occurs during which the commission of crimes is unlikely. Among populations of students, artists, and other more "privileged" pot smokers in the United States there is no recent evidence of associated criminality; similarly in the famous "La Guardia Report" (1940) in New York City marihuana was not found to be either criminogenic nor associated with criminal subgroups. With regard to traffic accidents, data is lacking. One study by Wendt (1954) in the United States using a cannabis-like compound suggested that motor performance was not impaired but that the ability to shift attention was reduced. Effects are no doubt related to dosage but no studies on varied dosage using driving tasks have been done.

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[2] References are listed at the end of the paper.

LEGAL CONTROLS AND THEIR EFFECTIVENESS

Except for very limited research purposes, marihuana is not legally available. Its acquisition and/or possession are punishable by law in the United States. Both felony and misdemeanor charges may be levelled; we are not aware of any studies of actual charges and dispositions. In spite of legal controls marihuana is said to be obtainable in most metropolitan centers in the United States. It is not, however, readily available in the sense that a naive person has an easy opportunity to obtain it. Acquisition is dependent upon being a member of, or having access to, some social group where it is used. The penalty has clearly not prevented all marihuana use nor the reported recent upsurge in use. To what extent controls on availability and the penalty risks have reduced use cannot be said. If one were to argue by analogy, taking alcohol which is available without penalty as a comparison, then one would suggest that legal controls have worked to suppress if not to prevent marihuana use. Some users interviewed recently argue that they have chosen to smoke "pot" because the laws are so patently inappropriate and they wish to signify their disapproval through direct disobedience. In California, a movement called LEMAR (legalize maraihuana) is now collecting signatures for a referendum asking the voters to make the drug legally available. There is in addition sentiment among scholars and some liberal legislators not to legalize use but drastically to reduce the penalities now written in the law.

OTHER CONTROLS

In some States efforts are made to prevent marihuana use by means of education in elementary and high schools. Review of some of the text and pamphlet materials that have been employed in the past, and casual interviews with students, suggest that much of this material may be not only out of date and blatantly incorrect, but also conducive to ridicule and consequent counterreactions among the now often well-informed youngsters. Demands not to use marihuana based on arguments against sin or self-indulgence may not be appropriate to sophisticated and secular metropolitan areas. Arguments against use based on claims of dramatically deleterious effects which are contrary to what is known cannot command respect.

Studies on persuasion show that for an informed audience, the most successful persuasion is one which acknowledges both sides of an argument. So it is that if educational efforts are to be undertaken with respect to the prevention of marihuana use, it would appear wise to base these upon (*a*) a rational policy about use which is itself based on objective appraisals of the significance and risks of use, (*b*) educational materials which are appropriate to the facts and keyed to the contemporary state of student knowledge and interest, and (*c*) evaluations of the effects of educational efforts so that unsuccessful or "boomerang" programs can be abandoned.

Aside from laws regulating availability and prescribing penalties and aside from educational efforts in the schools, we are not aware of other formal marihuana use control programs. It is likely that informal social and moral standards are more powerful determinants of drug-using behavior than are either laws or school programs. If that is so, control of marihuana use is vested in the home and among youthful peer groups. It would be of interest to learn how parents and peers come to adopt standards about marihuana, and how these standards are applied, and what events produce change in views about drug use among parents and peer groups. No such studies have been done to date.

COMMENT

We have suggested that educational and legal efforts should reflect a rational policy about marihuana. We have further suggested that policy itself should be based on the facts. The inadequate data available today indicate that risk of crime, accidents, and suicide (and of undesirable physiological side effects) are not likely to be greater than those associated with alcohol (and may be less). If the equivalence between alcohol and marihuana is to be accepted as an operating assumption until more facts are at hand—and we think that is a prudent position to take—it then follows that a public debate is in order with regard to the best regulation of marihuana.

It must be acknowledged that there are other "facts" besides those of risk which will enter into policymaking.

Perhaps the most significant of these is the widespread law enforcement and public belief that marihuana is as dangerous as heroin in terms of dependency-producing potential and that its use is associated with criminality. These beliefs, even if incorrect, are facts to which policy must address itself. Since there is no strong evidence (although there are some suggestions in the clinical literature) of the medical value of marihuana, there cannot be said to be any urgent reason to make it available, except for research purposes. Similarly if there is a parallel in kinds of outcomes between it and alcohol, there is clearly a risk of unknown proportion that increased marihuana availability, as for example with its legalization, might lead to increased dependency and dangerous outcomes of the sort associated with alcohol itself, the latter unquestionably being a "dangerous" drug in the social rather than legal sense. The recent experience of Asian and African countries is compatible with such a fear.

In the meantime there appears to be good reason to encourage research on marihuana which in turn requires increased ease of obtaining it and permission to employ it on human subjects for bona fide experiments. There also appears to be good reason to moderate present punitive legislation so that penalties are more in keeping with what is now known about risks; that is, they are not great. A revision of penal codes so that marihuana acquisition and possession becomes a misdemeanor only would not seem inappropriate. In addition, since the significance of marihuana use may well be for some persons that of rebellion or disrespect for law or tentative explorations in criminality, or it may portend developing dependency proneness on drugs as such, it would appear worthwhile for apprehended persons to undergo social and psychological (psychiatric) evaluations. If destructive tendencies (toward self or others) are found the person can then become the subject of nonpunitive rehabilitative or preventive efforts by welfare, medical, probation, or community psychiatric agencies.

In point of fact we do not know if such preventive or therapeutic efforts are of value; the hope is that they will be. We may at least expect them not to be harmful.

TENTATIVE RECOMMENDATION

In consultation with police, legal, and health personnel and with participation of research workers and interested citizen groups to formulate procedures (*a*) allowing for increased access to and human experimentation with marihuana by bona fide research workers, (*b*) to encourage funds for epidemiological research on drug use aimed at defining the characteristics of users and nonusers, their interests, conduct, health, etc., (*c*) to revise present penal codes so that marihuana acquisition and possession becomes a misdemeanor rather than a felony, (*d*) to support research and practical experiments in education, in schools and among parents and peers, focusing on conveying information about drugs which encourages nondamaging conduct, (*e*) to assume a policy stance of flexibility and objectivity which will not only allow for but anticipate that changes in legislative, health, and educational programs will occur as new facts about drug use arise and as new public problems or benefits become apparent.

In addition to the immediate steps set forth above, there are several areas in which long-term endeavors may be envisioned. We conceive of these to involve planning and consultative efforts with law enforcement agencies, with health and behavioral scientists, and with legislators. Work with the public both in terms of assessment of views on drug use and on the determinants of those views and educational efforts designed to alter incorrect opinions might also be appropriate. It is premature to set forth in this paper the details of these several efforts.

In general, the goal would be to provide a common base among informed and interested persons and institutions for planning—in concert—revisions in the law, in police procedures, and perhaps in public health and other medical-psychiatric practice so that marihuana and related drug use—and we must stress here that marihuana is frequently but one of a number of drugs being interchangeably used—can be handled with minimum cost to the taxpayer, minimum damage to the offender, with minimum strain on the police, and without creating anxiety among the public which in turn expresses itself as pressure on legislators for inappropriate laws. These goals, while sounding utopian, may very well be capable of at least partial achievement for of all the drugs considered in this report, marihuana is the one where there is the greatest discrepancy between public beliefs and probable drug effects, and between present versus reasonable legislation. The development of a moderate and consistent policy will much improve the present state of affairs.

HALLUCINOGENS

A group of drugs whose effects often include imagery and changes in felt sensory intensity—less often hallucinations as such—including lysergic acid diethylamide, LSD–25, dimethyltriptamine, DMT, mescaline, peyote, and others.

DISTRIBUTION

Naturally occurring in many plants (mushrooms, cactus, tree barks, flower seeds, seaweed, etc.) and capable of being synthesized in laboratories, hallucinogens are widely distributed over the world.

EXTENT OF USE

Hallucinogen use has been restricted to relatively isolated nonliterate societies. Certain South and North American Indian groups and Siberian tribes have employed the hallucinogen historically. Within the last century the use of peyote by American Indians has spread widely and within the last decade the use of LSD, DMT, mescaline, and other products has been adopted in metropolitan areas of the Western countries, primarily in the United States.

USE IN THE UNITED STATES

No reliable epidemiological or "drug" census data exist. Use appears to be concentrated in young adults age 20 to 35 but there are signs of rather rapid diffusion to high school age levels and less rapidly to middle and older age adults. Employed in medical research, LSD has been given to small numbers of psychiatric patients, alcoholics, schizophrenic children and has been tested on terminal (dying) patients as a means of easing their distress. Employed in pharmacological and behavioral research, it has been given to volunteers, for the most part students. Employed by religious and philosophical seekers it has been given in institutions and centers, and other settings. These institutional uses account for only a fraction of current use; impressionistic but probably trustworthy reports indicate expanding social and private use of the drug derived from black market sources. Ease of transport and of synthesis make LSD distribution easy. The use of other hallucinogens, peyote for example (La Barre, 1938), has been fairly well confined to traditional (Indian) groups, but their use, too, is expanding to young urban people.

As has been the history with many mind-altering drugs, the pattern of LSD diffusion has been overtime from older prestigeful persons downward to younger less prestigeful ones, also from institutionalized medical and religious (or pseudoreligious) settings to more secular use (Blum, 1966). With secular use, a drug becomes "social," use is subject to less contraint, and greater variability in outcomes can be expected as a greater variety of personalities, settings, and expectations are involved. At the present time, it would be unwise to venture any estimate of the number of Americans who have tried one or another hallucinogen; any numerical estimates must be suspect. One may presume that given a condition of continued easy availability of the drug plus wide publicity about its favorable effects, use would expand rapidly; historically the epidemic spread of tobacco smoking, opium use, and distilled alcoholic beverages provide illustrations. What effect current legislation to control manufacture, distribution, sale—and in some States, possession—will have on LSD use cannot be said at this time. It has generally been the case that interest in drugs can be channeled but not repressed; so it is that the choice of available drugs may be limited, but not the practice of using one or another drug. Historical examples showing shifts are those of opium to heroin, hashish to alcohol, and more generally from naturally occurring milder drugs to synthetic stronger ones.

CHARACTERISTICS OF USERS

In the United States—as has been indicated—peyote use is concentrated among American Indians, but does not occur among all tribes. LSD, DMT, etc., were first confined to physicians and other research workers and then spread to their subjects, patients, families, and friends. Until a few years ago, LSD remained limited to an "elite" group of successful professionals, artists, and communications industry personnel, their families and friends. These same groups still appear to be using hallucinogens, but the concentration of use appears to have shifted to younger persons. Among teenagers, motorcycle club members, delinquents, urban poor and minorities, etc., there are reports (Senate Subcommittee on Government Reorganization, 1966) of spreading interest, suggesting the expected diffusion down the socioeconomic scale. No common psychological or sociological features may be expected among the users of any secular and social drug; different people take drugs for different reasons. Within groups sharing common sociological characteristics it is sometimes possible to differentiate drug-interested persons, regular users, heavy users, etc., on the basis of psychological or background factors. For example, among graduate students one study reports that LSD-interested persons are more introverted and at the same time more excitement seeking than disinterested persons (McGlothlin and Cohen, 1965; McGlothlin, Cohen, and McGlothlin, 1966). Similar studies comparing psychological and background characteristics have identified certain differences among those trying (and not trying), continuing (and discontinuing) to use, and becoming dependent (and not becoming dependent upon) other drugs, for example, tobacco, heroin, alcohol (Blum and Associates, 1964).

REPORTED RISKS

Risks reported in popular articles include, especially for LSD, psychosis, suicide, continuing undesirable personality changes, release of sexual and aggressive impulses (leading to murder, rape, homosexual episodes, etc.), habituation, hallucinatory redintegration (return of the LSD state unasked and without taking the drug), development of interests in illicit drugs (marihuana, "goof balls," etc.), development of "cult" interests, and consequent warping of ordinary social outlooks, reduced work and social effectiveness, risk of divorce, increased accident risks when driving under drug influence, etc. Its exploitative use (control, seduction, purposeful production of psychoses) has also been reported.

VERIFIED RISKS

Psychosis following LSD is verified (Blum and Associates, 1964; Cohen, 1962; Downing, 1966); there is no adequate estimate of the frequency of psychosis as a function of incidence of use. Mescaline psychoses are also verified. Some psychotic reactions are temporary, many are now "treated" at home by the subject's friends; counteracting tranquilizers (e.g., thorazine) are now sold on the black market as part of the LSD "trip" equipment. Other psychotic reactions require long-term hospitalization. The most recent study available to us, that of Ungerleider, Fisher, and Fuller (1966) studied 70 post-

LSD psychiatric admissions during a 6-month period in a Los Angeles medical center, these patients representing 12 percent of all admissions during that period. One-third of the LSD patients were psychotic on admission; two-thirds of the patients required more than 1 month of hospitalization. Recently reported in California (San Francisco Chronicle, 1966) is teenage use of jimsonweed (datura stramonium) a substance employed by Luiseno and Chumash Indians to achieve visions. Deaths among these Indians occurred following overdose (Harner, 1966) and overdose among contemporary youth may also be expected to lead to illness or death. Suicide attempts are hard to distinguish from bizarre behavior occurring under LSD, for example jumping from windows because "I can fly," so it is that although suicidal feelings are reported and clinical workers describe attempts, there is no sound data on the probability of suicide attempts as a function of dosage, setting, personality, incidence of use, etc.

Crime associated with hallucinogen use appears to have been minimal. Police reports before a California legislative committee emphasized disturbances of the peace (1965) rather than felonies. Occasional accounts of homicide (see New York Times, June 5, 1966; also Geert-Jorgensen, 1964), violence, resisting arrest, etc., have not been subject to followup case studies. It would appear that insofar as decent citizens take hallucinogens their behavior will remain lawful. We may expect that with the expansion of hallucinogen use to delinquent groups—and perhaps because it is now unlawful in some States, so that its use becomes criminal—a greater frequency of crime will be reported. A tangential remark is offered here. It is the person, not the drug, which is "responsible" for criminal acts. When an already delinquent youth takes LSD and commits yet another delinquent act, it may well be that the timing or expression of the delinquency is shaped by the drug-induced state of mind, but—as an example—aggression will not be a drug phenomenon. Generally speaking, one would expect (although the scientific evidence is far from adequate) that well-integrated people under heavy drug doses will not do things contrary to their ordinary conduct. Less mature, more neurotic or otherwise less well integrated persons would seem to be more vulnerable to the acting-out of impulses, the temporary expression of conflicts or of being persuaded by others to misbehave. Consequently, one's review of crimes reportedly committed under drug influence must attend to the prior criminal and sociopsychological history of the offender. It is also necessary to have regard for the role of clouded judgment or reduced muscular coordination in producing behavior (e.g., a traffic accident leading to manslaughter) that is criminal. There can also be long-run changes associated with drug use, as for example, the clouding of judgment associated with habituation and drug stupor or in psychotic personality change, where criminal acts may conceivably occur (e.g., smuggling marihuana, perjury, theft) as part of a poor judgment syndrome.

With regard to vehicle accidents and hallucinogens, there have been no studies and no verified reports in spite of some remarkable "I was there" accounts. Experimental work showing slowed responses and reduced information processing make it highly likely that accidents will occur when under hallucinogen influence. This expectation should be tested in laboratory studies.

With regard to the other claims about hallucinogens—dependency, social and work decrement, divorce, etc.—the scientific sources are reliable but samples are small and insufficient followup studies exist.

COMMENT

It is particularly difficult to assess either the significance or the social effects of the hallucinogens during the present period when there is such a widespread change in the pattern of use. The present LSD "epidemic" generates interest and alarm as well as social research; unfortunately, the research results take a while to be generated—by which time they may no longer be applicable. As a best estimate one may suggest that any powerful drug produces dangerous side effects and that any powerful mind-altering drug is likely to alter judgment and conduct, some of which alteration is likely to make trouble for someone. But the problem of trouble over frequency of drug use remains a critical one and until the facts are at hand any extreme programs—either for the use of the drug or for punishment of use—would appear precipitous. Indeed, the present spate of publicity, whether crying alarm or claiming untold delights, is likely to be highly undesirable in itself; creating interest in the use of potent substances among a number of young people or disturbed personalities who are clearly ill-equipped to handle an intense drug experience. Similarly, this same publicity creates fear in the public and generates pressures on legislators to pass premature punitive legislation. We agree with the present plans of the National Institutes of Health—notably spurred on by Senators Robert Kennedy and Abraham Ribicoff—to conduct epidemiological research on expanding American drug use and to finance further research on the hallucinogens. We also agree with the present policy of the Food and Drug Administration setting up controls over the manufacture and distribution of LSD but not making possession a law violation.

Precipitously, several States (California and Nevada) have made possession unlawful. Peace officers have pressed for such laws partly because of the difficulty they have in proving intent to sell in cases where persons possess drugs at the time of arrest, but where no long preparation of a case has taken place, so that a sale is witnessed by officers. The dilemma of the law enforcement people is genuine and arises out of pressures on them to "crack down" on sales alone, since the (mostly undercover) effort in such cases consumes an immense amount of time. The arrest and conviction of those possessing drugs is much easier. Since much police experience with narcotics suggests that those possessing and those selling will be one and the same (except at upper echelons of organization), the popular desire to "bear down heaviest" on drug sellers results in fact in bearing down on user-possessors. Whether or not the narcotics seller-user pattern will be repeated with LSD and the other "soft" drugs is not yet known. It remains likely that some of the best organized production and distribution will be by persons not users; whether or not they can be controlled by local police using ordinary procedures is a question beyond the scope of this report. In any event, it must be recognized that if the law does outlaw sale, but does not allow arrest for possession, whether this be for LSD, marihuana, or any other drug, the work of the police will be long and hard and the public must not expect large numbers of arrests. As a corollary it is quite possible that such a policy would, as many law enforcement persons might fear, result in less suppression of illicit drug traffic and subsequent greater use.

Should this prove to be the case—and an evaluative effort is most strongly recommended to find out—there are several alternatives. One is to accept some illicit use as a fact of modern life and to concentrate on its control through educational and social rather than legal means. Another is to retain the nonpunitive aspects of the law, but nevertheless to require mandatory examination of all illicit and dangerous drug user-possessors by health, psychiatric, and possibly welfare (or other sociocriminological) authorities. Any found to be ill, disturbed, or otherwise maladapted might be referred to outpatient clinics for care or, failing their appearance for treatment, be subject to hospitalization under public health rather than criminal codes. These suggestions are only tentative and can be seen to follow present developments in the treatment of alcoholics and narcotic users. They also introduce serious problems of civil rights in terms of deprivation of liberty by health officers without due process. Treatment programs of a mandatory nature cannot be defended until much needed evaluation takes place to assure us they do, in fact, have a possiblity of working. Further consideration of these points is beyond the scope of this report.

RECOMMENDATIONS

It is recommended that Federal agencies be encouraged to support clinical and experimental research on the hallucinogens and epidemiological studies of population drug use. It is recommended that current FDA codes on hallucinogens be accepted as adequate, at least until more is known, and that individual States be discouraged from making hallucinogen possession a felony. It is recommended that the difficulty of the police task in controlling illicit drug traffic be acknowledged, especially when arrest for possession is not possible. In consultation with persons and staff groups interested in the prevention of drug dependency and in rehabilitation it is further recommended that various plans and programs for nonpunitive handling of the user of illicit drugs be evaluated. (For one such evaluation see Blum, Eva, and Blum, Richard, "Alcoholism: Psychological Approaches to Treatment," in press.) It is apparent from our comments and recomendations that we do not consider hallucinogen use to be a phenomena divorced from other forms of drug use. We are aware that there is disagreement about whether or not a particular drug use (especially alcohol and LSD) is a special case rather than part of a generalized drug picture. On the basis of our assumption and because of the differing positions others hold, it is recommended that general studies be continued which attend to all aspects of drug use, seeking to define both similarities and differences by drug or classes of drug as well as by user or population use habit characteristics.

As a final recommendation we would request of the mass media an emphasis on less sensational reporting and feature writing in regard to LSD and other drugs, would invite the public to give their legislators a moratorium during which time knowledge can be evaluated and reasonable approaches proposed, and would generally suggest as a matter of school and public health education that an effort be made to admit to uncertainty and to restrain emotion in the consideration of drug effects and the changing pattern of drug use.

STIMULANTS

STIMULANTS

A variety of substances may act as stimulants in terms of elevating mood, preventing fatigue or leading to short-term improvement in performance. Placebos, alcohol, tea, coffee, cigarettes, are so employed. Our focus here is on the major stimulant employed pharmacologically, amphetamine.

DISTRIBUTION

The amphetamines are a manufactured product available in all countries where Western medicine is practiced. Their concentration appears to be the same as the concentration of medical care, general pharmaceuticals, etc., namely in metropolitan areas. Nations which have reported amphetamine abuse include the United States, Great Britain, and Japan.

EXTENT OF USE IN THE UNITED STATES

Amphetamines are widely prescribed by physicians in attempts to reduce weight, control fatigue, overcome minor depressions, and in psychiatric care, in the treatment of behavior disorders in youngsters. In addition to supervised medical use, amphetamines are apparently widely employed in self-medication by persons seeking to combat lethargy, overweight, and fatigue. In this latter context, use by students studying for exams, by truck-drivers and by nightshift workers is described (Roose, 1966). Social and private use is also reported for persons seeking excitement or mood changes in the sense of "kicks" or "highs." No drug census has been taken so it is not possible to describe the actual incidence of use by population groups for the Nation as a whole. Social, criminological, and legal studies have identified use among late adolescents, including delinquents but extending to others said to be "rebellious," "wild," or simply "party going." In the United States, entertainers, actors, and other show business people are said to be users. In Japan during their postwar epidemic of amphetamine use, users were described as artists, entertainers, waitresses, and delinquents (Ministry of Welfare, Japan, 1964). Use was concentrated in the late teens and early twenties (Masaki, 1956). An English study (Scott and Willcox, 1965) described young occasional or party users as in no way delinquent or psychopathological; chronic users were however youngsters with personality disorders who came from unfavorable home settings. Other data supports the view that amphetamine abusers and those prone to dependency are badly adjusted youngsters before they turn to amphetamine use.

Japanese statistics (Masaki, 1956, in WHO report) showed at the height of the epidemic 7 percent of the population were taking "wake-amines" and 2 percent were abusers. Among Japanese arrested for use, half were said to be dependent. An Indian study (Banerjee, 1963) among students found 11 percent using amphetamines for studying, but none abusing the drug. In the United States 75,000 pounds were produced in 1959, enough for 20 tablets per capita. In 1962 a survey of producers showed a minimal production of 4½ billion tablets (10 mg. strength) or 25 tablets per person (Lewis Laster, 1964). Half of that production was reported by FDA to be going into illicit distribution channels (for social and private use). Recent arrest data shows an increase in arrests for amphetamine use (San Diego Narcotics Detail report to Senate Hearings, 1962). There is some evidence then that production and use (presumably medical, self-medicating and social) is increasing.

REPORTED RISKS

Habituation (dependency) including physiological addiction (withdrawal symptoms present), traffic and airplane accidents, psychosis, medical ill effects including shock, convulsions, coma and death, and violence are among the risks which have been reported. For example, claims before the U.S. Senate hearings included, "children or youths . . . prone to sexual offenses," "a law-abiding person may go berserk . . . may participate in mass violence . . .," "extremely dangerous," "proven to be a major contributor to this Nation's crime problem," and "the use of these drugs has a direct causal relationship to crimes of violence." With reference to accidents, claims before the Senate subcommittee included, ". . . a considerable number of serious accidents on the highways and in the air were traced to the use of amphetamines by persons operating such vehicles."

VERIFIED RISKS

Research done to date directly contradicts the claims linking amphetamine use either to crimes of violence, sexual crimes, or to accidents. For example, a careful search of reports reveals no case of an airplane accident attributable to amphetamines. Truck accidents, commonly attributed to high rates of use by truckers, upon careful search reveal—using Senate hearing data as a base—that in 1957 (the year for which statistics were presented) of 40 truck accidents with amphetamine use by the driver implicated, only 13 were described as being due to driver-performance error presumably due to amphetamines. These 13 cases were out of 25,000 truck accidents filed for that year, .0005 percent (James Fort, 1964). Experimental work leads to findings like those of Miller (1962) reporting no detrimental effect on driving within normal dosage ranges or Murray (1960) finding that driving skills may be improved, especially for fatigued persons or those with depressed performance due to other drugs (e.g., barbiturates, alcohol).

With regard to crime the San Diego Narcotics Detail in a background study of offenders found those arrested for dangerous drug violations (including amphetamines) had no history of other criminal violations. Scott and Wilcox (1965), in a very careful study compared amphetamine-using delinquents with nonusing delinquents in England and found no differences in overall delinquency rates. But there were no crimes of violence, no road accidents, and no firearm possession violations in the amphetamine-user sample. In another study amphetamines were given to delinquents as part of a treatment effort and under these drugs the boys were found to show better adjustment and better work compared to delinquents not so treated (Eisenberg, 1963, and Pasamanick, 1951). Regarding sexual offenses, an observational study (Scott and Wilcox, 1965) shows loss of sexual interest among amphetamine-using youngsters. A review of the literature and of all evidence submitted to Government hearings shows no verified case of sexual offenses arising out of amphetamine use. This does not exclude delinquent sexual behavior among youths who, as part of their pattern of maladapted behavior, also use amphetamines. There is some evidence that judgment can be impaired by use in some cases and that risk-taking may increase; again the personality and social context are likely to be major factors influencing actual behavior.

With reference to dependency and physiological ill effects, the evidence supports their occurrence. Twenty percent of a sample of users studied showed dependency, but withdrawal symptoms (physical) occur rarely (Kiloh and Brandon, 1962). In a Boston hospital study of drug abusers (Schremly and Solomon, 1964), the abuse (dependency) of amphetamines and barbiturates (the up-and-down cycle) was observed in a few cases. The suggestion is made that several drugs will be found to be used sequentially or in the "multihabituation" pattern whenever amphetamines are involved in dependency. One clinical study of three medically supervised patients using heavy amounts of amphetamines indicated that neither dependency nor behavior toxicity need occur. General observations on amphetamine use would confirm the view that dependency is by no means inevitable but rather appears to occur only when some prior personality disturbance is present. Further research is much needed to find out just what kinds of persons are at risk of becoming dependent on drugs. The work of Chein and his colleagues on heroin ("The Road to H") provides an excellent example of what can be done.

Psychosis is an outcome not often mentioned by those alarmed at amphetamine abuse. Nevertheless psychosis does occur and, unlike crime and accidents, seems to be a genuine risk. Breitner (1963) describes cases of psychoses after use of amphetamines prescribed for weight control and for mood elevation. He suggests, as does Brandon, and also Beamish and Kiloh (1960) that many cases admitted as paranoid psychoses may be unrecognized cases of toxic reactions to the amphetamines. A general assumption is made by many psychiatrists, one insufficiently unsubstantiated by research, that psychotic reactions to drugs occur only when there is recognizable prior personality disorder.

COMMENT

One serious risk that we have not discussed arises from the fact that the nonmedical use of dangerous drugs as with marihuana and narcotics, can lead to arrest and incarceration. Many sociologists and criminologists contend that arrest and subsequent experiences when one is treated as a criminal produce many injurious consequences and increase the likelihood of expanded rather than reduced criminal and socially maladaptive behavior. Especially in the field of drugs where use is a crime regardless of whether or not any other damaging behavior occurs has there been discussion of the undesirable features of "turning the person into a criminal" through treating him like one and exposing him to contact with "genuine" offenders. As an alternative it is often recommended that criminal prosecution be limited to criminal behavior as such (i.e., crimes against person and property) and that drug use be handled (*a*) as a normal phenomenon, since this is a drug-using society except (*b*) when dependency occurs or other behavioral toxicity (aberrant actions, suicidal impulses, psychosis, etc.) emerges at which time the person may be subject to medical-psychological-social rehabilitation efforts. The evidence for arrest and prosecution as methods more likely to create a criminal out of a drug abuser than to correct him remains very contradictory. The situation is complex and no simple predictions seem tenable. It is made more complicated, as we indicated in the marihuana discussion, by the lack of assurance that ordinarily psychiatric-social rehabilitation efforts will work either. Even so, it can be argued that on grounds of economics and humanity it may be better to handle any person abusing drugs (that is anyone dependent and acting in damaging ways) by other than criminal procedures. On the other hand, proponents for legal restraints call attention to the role of law as an educative device to warn persons of drug risks and as a means of controlling drug availability which is, without much doubt, an important factor in determining at least which drug a drug-interested or potentially drug-dependent person will try. Proponents of punishment also contend that the stance of the law does influence use among reasonable persons by making use itself risky and by setting forth the general message, a social consensus, that drugs are to be handled with caution and that abuse is disapproved. Many citizens would subcribe to this view of laws as a means for expressing ideals, educational goals, and social consensus. Whether or not criminal codes constraining drug use itself do accomplish these ends, regardless of their apparent inability to prevent or correct some drug dependency, remains a question. It is beyond the scope of this report to consider these problems further. We do call attention to the debate which now occurs about ways and means of preventing and correcting drug abuse and to the possibility that revisions in current punitive approaches may be in order. We would also suggest that studies of what laws do accomplish in areas of drug use and vice are very much in order.

In the introduction to this report we said that abuse is itself an emotionally loaded word. What is said to be a risk may reflect fears rather than facts as well. In reviewing the claims made about the undesirable outcomes of amphetamine use (and of marihuana and opiate use as well), one is struck by the lack of support for the claims advanced by reputable and well-intentioned persons, including government officials, to the effect that these drugs cause crime and accidents. We have taken special care in reviewing the claims of risk to trace back reports to their sources. We have, for example, gone back to the original sources for the very important paper produced by WHO (World Health Organization) which concludes that amphetamine risks are high for accidents and implicate amphetamines in crime as well. Looking at the references cited in support of the statements in the WHO paper one finds, that in some cases, the reference has little relevance to the statement. In other cases, one finds that the reference itself is not a scientific report or other careful observation but only an impression or opinion written in as a letter or clinical note to one or another medical journal. Sometimes several references are cited which upon inspection are only quotes from an earlier source or simple repetitions of a claim. We find this distressing for several reasons. First, it suggests that scientific and official reporting about drug effects may itself be subject to strong bias and may reflect preconceived ideas rather than an adequate appraisal of the evidence. Second, it makes the job of layman, official, or scientist harder in the sense he cannot rely on reports by presumably objective agencies but must return to original sources and thus spend unnecessary time and effort. Third, it reflects what is seen daily in the popular press, what is heard in official hearings, and what we see and hear around us in social conversation to the effect that opinions and emotions about drug use and drug risks are strong but that the evidence may be weak.

We have also taken time to survey some of the recent popular articles about amphetamine abuse, tracing their development in magazines. One finds the evolution of alarm and a sense of crisis, one article expanding on the one before, elaborating claims, exaggerating unsubstantiated cases, and becoming more intense in the cry for legislative control. Sensationalism can only be part of the reason; the public must be receptive to such snowballing appeals and such receptivity reflects, we believe, general public anxiety. This anxiety expresses itself about drug use and insofar as new drugs do present unknown dangers and known drugs clearly do have bad effects as well as benign ones, that anxiety is justified. Nevertheless the extreme feelings apparent, and the catering to bias in popular and purportedly authoritative publications, reflect more, we believe, than a reasonable worry about drugs. In keeping with the thesis in our introduction to this report we would propose that people are worried about people, not about drugs except as these are a mirror reflecting distress. What people are said to do because of drugs—to rob and steal and rape, to injure and kill one another on the highways, and to become dependent and psychotic—these are the things that people do and we—all of us—have good reason to be upset about them. But people do not need drugs to act in these frightening and damaging ways; and the general evidence is that drugs in fact play a very small part in the production of our overall rates of trouble. They do play some part of course and insofar as they do, they add to the already great social burden. What we suggest is that the worry about drugs is extreme because somehow these substances have come to by symptoms of individual uncertainty and distress and can be used as explanations of why bad things are happening. As an explanation of the otherwise inexplicable willingness—or compulsion—of humans to damage themselves and one another, drugs are scientifically insufficient, but in terms of a public explanation they seem to serve that purpose. Our speculation, and it is only speculation without one shred of evidence to support it, at least focuses on the irrationality of much that passes for fact about drug abuse. It also suggests that further lawmaking about drug use need attend to at least two matters: One is that a law which is not based on facts and which has an unknown effect as far as control is concerned—or in terms of making the problem worse—is not likely to solve real problems associated with drug use. The other matter is that the apparent satisfaction produced by passing a criminal law directed at drug users must have some social function, perhaps it does at least alleviate public anxiety or allow one to single out for punishment at least someone who represents the bad things happening. If that is the case, then any revisions in handling drug users which focused only on users and on the facts of risk, but which failed to realize the intensity of public worry, and perhaps satisfaction with punitive approaches, might well generate further troubles—this time not for drug users but for the public deprived of at least this form of expression. If any of these speculations are correct it would follow that public soundings, public education, and direct efforts to recognize and try to resolve relevant public distress over unacceptable deviation and criminality—which is in fact one task of the President's Commission—must precede and accompany all provisional efforts at handling drug abuse.

RECOMMENDATIONS

A general revision of criminal codes pertaining to illicit drugs should be undertaken. A reasonable change might eliminate criminal prosecution provisions for the possession of dangerous drugs including the amphetamines. Consideration may also be given to reducing penalties for acquisition and perhaps for sales under certain circumstances. Such reforms, themselves to be provisional on the assumption that drug use patterns will continue to change, should be carefully planned in concert with interested groups. Extreme demands by interest groups must be muted by having available reliable scientific evidence on use, risks, and control-effort impact.

Studies of the assumptions which underlie demands for particular forms of drug legislation should also be undertaken including studies of public attitudes and emotions, of law enforcement and church groups, and of reformers as well.

It will be helpful if commissions or other bodies planning legislative changes have before them careful evaluations of the actual effects of dangerous drug and narcotic control laws. These effects should be defined not only in terms of impact on drug users and on drug-interested potential users, but in terms of public beliefs and emotions and in terms of the impact on interest groups "displaced" by reforms, as for example narcotics police, temperance groups, narcotic treatment institutions, and the like. Because drug users themselves do not constitute an effective "lobby" but must be represented by others, as for example the present Senate subcommittee concerned with Federal programs for the handicapped, the function of present laws and the impact of changes on other interest groups (lobbies) should be anticipated in advance. New legislation cannot be expected to satisfy everyone, nor should it attempt to, but it must base itself on the correction of current inconsistencies, on the anticipation of known effects, and can plan on meeting standards of economy, humanity, and good sense; standards now not always found in measures affecting drug use.

Other means of reducing drug risks aside from laws must be stressed. Expanded public education, direct efforts to correct social and personality disorders conducive to drug abuse, expanded education of physicians, druggists and other drug "gatekeepers" may well prove beneficial. As with most other public efforts directed to reduce social ills and mental disorders, it will be unwise to be overly optimistic about producing immediate change. It would also be unwise to expect specific programs to solve more general human problems. So it is that broad scale programs such as those envisioned in welfare, antipoverty, mental health, public health, and other progressive efforts can be expected to contribute to the control of if not to a reduction in drug abuse.

In planning any program aimed at preventing or correcting drug abuse, it is important to be realistic about the limitations of any effort. As a society in the habit of using drugs and with the approved expansion of pharmacological research and the medical application of drugs, and with the ever-present strain of technological life, there is reason to expect medical, social, and private drug use to expand. Much of this use is benign and without serious risk and no free modern society would seek to prohibit such use. Risks and some bad effects will be inevitable, at least within the present generation.

A quote from Dr. Maurice Seevers, Professor of Pharmacology at the University of Michigan is appropriate:

> The obvious lesson of history is that a certain segment of the population, probably a much larger one than we would like to believe, must find release or relief in drugs. . . . It is up to society, therefore, to find the means by which this may be accomplished with minimal hazard to the individual and to itself (J.A.M.A., 1962, *181* (2), 92–98).

TRANQUILIZERS

DRUG CLASS

Tranquilizers include a variety of different products, including some drugs which act essentially as sedatives, designed to counteract anxiety and agitation, control psychotic behavior, and to energize seriously depressed persons. The modern chemical families of tranquilizers have been introduced into Western medical practice only in recent years. Tranquilizers are sometimes classified as strong and mild depending on their chemical structure and effects. In practice there is overlap between drug classes as sedatives and those considered tranquilizers.

DISTRIBUTION

As naturally occurring substances, tranquilizers have been employed in folk medicine in Asia and perhaps Africa and Europe for centuries. As prepared pharmaceuticals, their use is primarily in Western medical practice, not necessarily psychiatric practice alone. Distribution is probably associated with availability of medical care as well as with economic factors associated with therapeutic drug use.

EXTENT OF USE IN THE UNITED STATES

There have been studies of prescription practices showing that from 6 percent (Shapiro and Baron, 1961) to 10 percent (Baron and Fisher, n.d.) of all medical prescriptions contain tranquilizers. Production figures from the pharmaceutical industry indicate that in 1963 over 1 million pounds of tranquilizers were sold in the United States (U.S. Tariff Commission). Unfortunately, studies of prescriptions and of production do not tell us about what kind of people take how much of a given tranquilizer how often. They do not tell us about how formal medical channels for prescription are converted into informal channels for distribution without medical supervision. There are enough tranquilizers available to allow every citizen to take them often; since this is probably not the case, the best estimate is that some citizens use them quite heavily.

CHARACTERISTICS OF USERS

Prescription studies show that women more often than men receive tranquilizers as patients (Shapiro and Baron, 1961; Baron and Fisher, n.d., Glatt, 1962). A drinking survey shows that middle-aged people use tranquilizers more than other age groups (Cisin and Cahalan, 1966). United Nations and WHO personnel estimate that tranquilizer users tend to be middle and upper class respectable persons.

REPORTED RISKS

Tranquilizers have been implicated in suicide (Senate Hearing, 1964), in drug dependency (including stuporous or slowed behavior [Senate Hearing, 1964]), in traffic accidents (New York Academy of Medicine report, 1964), and, in one report, in aggressive behavior (WHO report, 1965). They are contraindicated for airplane pilots. Recent Food and Drug Administration Hearings (June, 1966) have yielded testimony to the effect that one tranquilizer, meprobamate, leads to dependency. Lemere (FDA Hearings, 1966) contends that 1 percent nonalcoholic and 4 percent (former) alcoholic (addict) users are dependent on that drug. Physical addiction is also reported, animal studies showing (FDA Hearings, 1966) physical "abstinence" symptoms including death when meprobamate is withdrawn. A variety of medical risks have also been described, some so severe that particular products have been removed from the market.

VERIFIED RISKS

In a study of 1963 suicides, Berger (1966) found 12 percent used analgesics and soporifics. Of these, barbiturates accounted for 75 percent and tranquilizers an unknown portion of the remainder. It is clear that overdoses can lead to death and that purposefully or accidentally (as for example, in potentiation with alcohol), tranquilizers have been used in suicide, but would account for less than 2.5 percent of all suicides occurring in the United States. Given enough equivalence in overall production in tranquilizers as opposed to barbiturates so that both classes of drugs are readily available, it is clear that barbiturates are preferred over tranquilizers as suicide means. In a study of New York City adolescents the Poison Control Center found tranquilizers used in 12 percent of the attempts in which one or another chemical was employed (Jacobziner, 1965). (Aspirin was used in 35 percent, barbiturates in 35 percent.)

Dependency data is spotty; clinical studies make it clear that withdrawal symptoms do occur, so that tranquilizers may be classified as physiologically addicting drugs (Ewing, 1958; Hollister, 1960). Autopsies and clinical observations indicate that an unknown proportion of persons are habituated. In a careful study of Boston hospital patients (Schremly and Solomon, 1964) out of 100,000 admissions six cases of tranquilizer dependency were found. Admitted patients were lower class persons; a hospital serving a different social clientele might have yielded higher figures.

There is no reliable evidence to the effect that tranquilizers are associated with antisocial behavior. Behavior may change and some observers may disapprove of changes, but crime itself has not been shown to occur. One may keep mind Dr. Jonathan Cole's statement that "behavior toxicity, like beauty, may be chiefly in the observer's eye" (1960). Behavior toxicity is a broad term and can be used to describe any form of presumably deleterious conduct.

With regard to traffic accidents clinical descriptions have stated that librium is associated with accidents (Murray, 1960). In simulated driving experiments contradictory findings emerge. Marquis (1957) found no impairment of driving ability, Loomis and West (1958) with a better experiment, found tranquilizers did impair performance, chlorpromazine for example by nearly 70 percent. Various doses of several different compounds given in test situations by Miller et al. (1962) showed some impairment with tranquilizers, but not judged to be serious for transient use. Chronic heavy dosage is thought to be a genuine hazard to driving. Frank (1966) has cited a study showing that a group of patients receiving a tranquilizer for 90 days had 10 times more traffic accidents than the population at large. In considering driving or other tasks where accidents can occur, one must note that the particular condition of the person as well as dosage and kind of drug play a role; "norms" or standards of acceptable driving skill are also but poorly established. For a nervous person a tranquilizer might improve performance over prior driving; old age appears to lead to considerably reduced driving skill, so that a good middle-aged driver on a tranquilizer might perform better than that same person at age 70 driving without any drugs. We have been unable to find simulated flight studies showing the effect of tranquilizers on flying skills.

CONTROL MEASURES

Available on medical prescription only, there is nevertheless considerable informal private use of tranquilizers without physician supervision due to the practice of prescribing large amounts which are refillable and can be distributed by patients. No black market distribution chains have come to our attention, but this does not rule out their existence. There is no public or official alarm over present use, even if it is acknowledged that behavior toxicity may occur. Consequently, present control measures have not been criticized.

RECOMMENDATION

There is a need for further work on tranquilizer effects on driving skills, but this might well be part of a sustained and large-scale study of driver performance under a variety of influences. Very considerable Federal encouragement and support for such traffic safety work and for later inevitable stronger controls on licensing and driving is recommended.

Suicide is another area deserving further attention through research; again, the emphasis should not be on which drug, but rather on the factors creating suicide risk and means to their control. The work of the Suicide Prevention Center (Los Angeles) and of the Poison Control Center (New York City) is exemplary.

If epidemiological work shows further expansion in public use without adequate medical supervision, or without patient or physician awareness of possible toxic somatic as well as behaviorally toxic effects, additional controls may be considered. These might well be in the form of physician and public education. Physicians, laboratory experimenters, and other "gatekeepers" (responsible people who introduce or "initiate" others into drug use), often seem unaware of the consequences of their well-intentioned acts. As a general policy, physicians and experimenters should be made more aware of the risk of continuing informal (unsupervised) drug use which follows introduction to *any* mind-altering substance. Professional schools and associations might well be asked to play a larger part in this education of gatekeepers.

BARBITURATES

BARBITURATES AS A CLASS

A number of substances have been employed to produce sleep, but our focus here is limited to barbiturates which are the most frequently prescribed group of sedatives. Other prescription sedatives are referred to in research cited here. Some sedatives, for example certain antihistamines, are available without prescription.

DISTRIBUTION

Barbiturates are manufactured products, available wherever modern medicine is practiced and where manufactured pharmaceuticals are sold. For the most part these are the technologically advanced countries.

EXTENT OF USE IN THE UNITED STATES

No drug census or epidemiological study has been made so that there is little good information about which people use barbiturates and how often. In 1963, drug stores filled 47,795,000 barbiturate prescriptions (Berger citing Gosselin Prescription Audits) and nearly 61 million for tranquilizers, but one cannot say how many of these prescribed drugs were used over what time period by what number of patients. Abuse is likewise difficult to assess, especially since case finding procedures are subject to error. Schremley and Solomon (1964) found for example that of 82 cases of all drug abusers (including barbiturates) identified in a Boston hospital, only six had been officially reported to an agency. In public health work and in police records, the problem of unreported cases ("the dark number") in crime remains a critical area of ignorance.

CHARACTERISTICS OF USERS

Surveys of drinking practices suggest that women employ barbiturates more than men (Sotiroff, 1965; Baron and Fisher, n.d.). Prescription studies concur. One authority, Isbell (1950), finds that barbiturate abusers are similar to alcoholics.

REPORTED RISK

Medical risks include convulsions, coma, and death; barbiturates are used in suicides. Accidental death occurs with particular risk when alcohol potentiates physiological depression. Traffic accidents and crimes have also been attributed to barbiturate use. Dependency including physiological addiction is reported.

VERIFIED RISKS

Barbiturate suicide is the most frequent suicide device used by women. Of all suicides in one county (Los Angeles) barbiturates accounted for about 20 percent (annual report of coroner of Los Angeles County, July 1955–1966).

A review of national statistics (Berger, 1963) shows drug suicides accounting for 12 percent of the annual total, 75 percent of these employing barbiturates. Suicide itself appears on the increase (about 16,000 in 1954 reported compared to about 21,000 in 1963—many are not reported at all) and drug suicides are becoming an increasing proportion of all suicides (5 percent in 1954, 12 percent in 1963). Barbiturates have risen in preference accordingly. Of attempted adolescent suicides in New York City, 33 percent used barbiturates (Jacobziner, 1962). In addition, poisoning and accidental deaths occur, some of which cannot be distinguished from suicides. For example, in 1965 New York reported 3,000 deaths due either to accidental or intentional overdoses (Medical Society of New York County). In 1958, over 1,100 cases of barbiturate poisoning were reported in New York City. Accidental overdose can occur (Fort, 1964, (b)) because of sleepiness or confusion following an initial dose after which further doses may unwittingly be taken (Berger, 1966).

Other than arrests for dangerous drug use as such there are no verified cases (at least coming to our attention) of any crimes against person or property occurring because of barbiturate ingestion. Dangerous drug use and arrests for that use appear to be increasing (Fort, 1964).

Regarding accidents there is not yet sufficient knowledge about the barbiturate role. Neil (1962) notes that "statistics are not available on the effect of drugs (other than alcohol which is associated with up to 50 percent of fatal accidents) on the overall accident rate." Inferential experimental evidence strongly suggests impairment of functioning in response to barbiturate use (Von Felsinger, 1953). For example Miller (1962) found marked decrease in reaction times; Loomis and West (1958) using simulated driving apparatus found that barbiturates produced impairment in driving skill. One hundred mg. twice daily produced impairment as great as that accompanying blood alcohol levels of 150 mg. ("drunk") usually associated with great performance decrement. California Highway Patrol researchers (1964) have sought further data on drug use and traffic fatality but found research difficulties in detecting barbiturates in hospital and accident settings. Quick and reliable determination methods would be useful. A German study (Wagner, 1961) of over 2,000 drunken drivers found that 11 percent admitted taking other drugs as well within the last 24 hours, mostly barbiturates. Sixty-seven percent of all the (drunken) drivers had had accidents; 70 percent of the alcohol plus other drug group had accidents, not a statistically significant difference. Concentrating on the alcohol plus sedative group (only 23), 77 percent had had accidents. The upward trend, even if not statistically significant, demands notice and is compatible with other studies on summation and potentiation with combined depressant drugs.

Dependency including physiological addiction is clearly present in chronic barbiturate use. Isbell found that 0.8 g daily for 6 weeks or more will produce severe addiction and in 60 percent of the cases toxic psychosis or delirium. Withdrawal symptoms resemble those produced by alcohol abstinence; alcoholics sometimes substitute barbiturates when alcohol is not available. In a Lexington (USPH hospital) survey about 23 percent of the addicts there also were using barbiturates (Hamburger, 1964).

Among the nonbarbiturate sedatives from which one may expect increasing problems are glutethimide compounds (Doriden). Clinical reports of psychological distress, physiological dependency, neurological disorder and death are accumulating (Lingl, 1966). Since psychotic reactions have been observed, the possibility of dangerous behavior occurring in connection with use or withdrawal from Doriden cannot be ignored. These findings lead to the general statement that many of the problems associated with barbiturates will occur with other sedatives.

COMMENT

Barbiturates are addicting, are used for suicide, can produce poisoning and accidental death, appear further to endanger those who have been drinking alcohol, and are likely to play a role in traffic fatalities. They cannot be implicated in criminal acts apart from their illicit use. The problem of suicide is not, however, a problem in drug control. It is a social and psychological problem and must be studied and prevented as such. Similarly the rising traffic accident rate must be considered overall. Drug use certainly plays a role here; the question is can drug-using drivers be identified in advance of their dangerous behavior and somehow prevented from driving? A consideration of alcohol accident prevention programs in Europe will suggest possible control devices. To what extent physicians themselves can play a role in educating their patients, or in watching for dependency and overuse preceding toxic effects remains a question. One of the critical problems underlying each of these questions is that of identifying the potentially or already abusing or drug-endangered person prior to his killing himself, hurting another in an accident, or becoming addicted.

The problem is not dissimilar from other case-finding needs in public health, in criminology, or in psychiatry. It is not impossible that these needs to identify citizens before trouble occurs—or afterwards but before they are dead—can be combined in community programs. One important focus will obviously be on drug-use habits; the excessive use of drugs may well prove to be a sign of general distress as well as of potential danger. Bearing on this is a recent finding of ours to the effect that 4 percent of a sample of persons admitting varied and frequent drug use also admitted to having attempted suicide with drugs (Blum, Braunstein, and Stone, 1966, unpublished). This sample also expressed dissatisfaction with themselves and their lives. We think it is likely that if drug abuse is taken as a symptom of distress and community-wide identification programs undertaken that preventive and rehabilitative measures may wisely be employed.

RECOMMENDATION

As an immediate need, inexpensive and reliable techniques for establishing the presence of mind-altering drugs (other than alcohol) in persons arrested or in hospitals are much in order. These techniques available for field use by police officers and other emergency personnel would be most useful.

Large-scale studies of traffic accidents focusing on the bad driver are in order. Out of such studies—but not before them—one envisions programs arising for careful prelicensing examination, periodic reexamination, driver education, and perhaps stringent legislation pertaining to those driving after drug use.

Community-wide programs of case-finding which not only focus on drug use but which are coordinated with public health, psychiatric, suicide, and criminological "dark number" research workers can be envisioned. Pilot projects should be financed along with pilot studies of prevention and rehabilitation once cases of troubled, ill, or dangerous persons are identified.

Efforts to educate druggists, physicians, teachers, and others as case-finders for barbiturates and other drug abusers are in order. Procedures for referral which do not work hardships on the drug users can be established.

VOLATILE INTOXICANT SNIFFING

DRUG CLASS

The class of volatile intoxicants includes all substances which when sniffed or inhaled produce altered states of consciousness (ether, nitrous oxide, paint thinner, some glues, gasoline, etc.).

DISTRIBUTION

As manufactured substances, these are available primarily in technologically advanced countries. As for sniffing as a means of drug ingestion, certain naturally occurring substances such as the hallucinogen parica are sniffed by South American Indians, while tobacco is sniffed as snuff. Opium and hashish may also be sniffed, but these are not primary routes of administration.

EXTENT OF USE

A New York City survey of identified cases in schools in 1962 revealed only 31 cases in 21 schools. Another simultaneous New York City study showed 46 cases in 31 schools. In the last 3 months of 1962 the New York City police reported 503 cases (87 reported by schools) and during the first quarter of 1963, 443 cases. Winick reports for New York City over 2,000 cases in 1963. Among 75,000 Stockholm schoolchildren, there were 20 paint thinner addicts identified during a 1-year period. From these figures, and others taken from Los Angeles, Denver, and Detroit, it appears that sniffing violatile intoxicants is a rare occurrence.

CHARACTERISTICS OF USERS

Most identified sniffers of volatile intoxicants in the United States have been children in urban areas. Studies of select groups show more males than females, and a median age of about 13. Minority group members may be overrepresented. A study of backgrounds reveals serious family problems including alcoholism in the homes of thinner sniffers. Winick describes glue sniffers as having low self-esteem, being anxious and passive, and having poor personality adjustment. Another study found sniffers to have delinquent histories prior to sniffing, to be poor students with school adjustment problems and unsatisfactory homelife. Not all sniffers are children; a Detroit study finds young adult "swingers" and the "gay crowd" to sniff nitrous oxide; some clinical observations have found anesthesiologists to be a high-risk group for anesthesia sniffing.

In our pilot study of a normal population, we found adults who had been sniffers as children to be in the heavy (or exotic) drug-use category in adult life.

REPORTED RISKS

Reported risks include death and physiological damage (liver), dependency, self-destructive acts, antisocial acts while under influence; use is also reported to lead to other drugs, including heroin.

VERIFIED RISKS

Although violence appears rare, some of the intoxicated children have been assaultive or suicidal. Physiological damage does occur. Hard core sniffers do appear to be troubled persons interested in drug use and susceptible to further drug experimentation on a road that may lead to further dependencies. Mild dependency to sniffing intoxicants may occur.

CONTROL MEASURES

Attempts to identify sniffers and to refer them to psychiatric authorities are predominant. Police appear to refer cases to other agencies but a further study of actual dispositions and later outcomes would be useful.

COMMENT

Intoxicant sniffing is, in itself, rare enough not to cause alarm. The identification of sniffers is, however, of great importance so that rehabilitative measures can be introduced to (*a*) prevent danger while intoxicated and (*b*) to forestall the otherwise very likely development of later dependency on other drugs and presumed criminogenic associations possibly arising out of interest in illicit drugs. It is clear from the present data that case-finding methods (through doctors, police, schools) may require elaboration. One recent effort has been attempts to reach patients through pamphlet materials. Since parents of the sniffers are apparently a less than satisfactory group, such direct education does not offer much help or hope.

RECOMMENDATIONS

To encourage school and public health people to develop new methods for case finding for children engaged in sniffing volatile intoxicants; also to recommend that each school, health, and police agency participates in a community-wide program for the referral of such children to psychiatric personnel.

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Appendix A–2

MIND-ALTERING DRUGS AND DANGEROUS BEHAVIOR: NARCOTICS[1]

by Richard H. Blum, assisted by Lauraine Braunstein

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DRUG CLASS: NARCOTICS

The most satisfactory definition is limited to opium and its derivatives and the synthesized analogs. These include a number of subclasses of opiates: (*a*) Opium and its preparations including morphine, heroin, codiene, Percodan, etc., (*b*) the Morphinan group, (*c*) the Benzmorphans, (*d*) the Meperdine group including demerol, (*e*) the Methadone group and (*f*) others including dithienylbutenylamines, hexamethylenimines, and benzimodazoles, among which are nonaddicting morphine antagonists such as Nalline. One must recognize that "narcotics" as described by law or in popular speech may include a number of drugs that are not opiates and which do not produce severe physiological effects upon withdrawal as do most, but not all, of the opiates. So it is that "narcotics" statutes may also include marihuana, cocaine, hallucinogens, and other drugs pharmacologically dissimilar to opiates. On the other hand, drugs which are centrally active (central nervous system affecting) and do produce strong withdrawal effects may not be classified as narcotics, for example, alcohol. In order to avoid the misunderstandings which popular terminology confers upon discussions of various drug classes, we shall, for the rest of this paper, discard the term "narcotics" and refer to opiates instead. Other sections of this report deal with other mind-altering drugs with abuse potentials.

DISTRIBUTION

The opium poppy, source of smoking opium and all derivative opiates, including heroin, is widely grown. Much production is legal and falls under controls which are part of the Conventions of the Commission on Narcotic Drugs of the United Nations. Countries producing opium for conversion to medical use under government control include Argentina, Bulgaria, Czechoslovakia, Germany, France, Hungary, Norway, Poland, Romania, USSR, Turkey, Burma, India, Japan, Pakistan, Australia, etc. It is to be noted that the United States is not an opium-producing country so that it imports all opiates to be medically employed. In 1962, for example, the United States reported (Permanent Central Opium Board, Addendum Report, 1963) the importation of over 127,000 kilograms of opiates. The crude opium imported into the United States is converted (manufactured) into morphine and other medications. In 1962 over 180,000 kilograms were processed (the difference between amount imported and amount processed by manufacture represents utilization of stocks on hand).

Medically employed opiates have a nearly worldwide distribution, Africa showing the least importation, processing and medical use. Medical use in Europe and the Americas is technological, that is, refined products such as morphine and demerol are in the hands of physicians. Use in Asia and the Near East is often traditional or folk medicine either in the hands of native healers or in family home remedy use. That use relies more heavily on opium itself than on its manufactured products.

The illicit use of opiates is found both in opium-producing and in opium-importing countries. There appears to be a general tendency for opiate-importing countries, which are primarily technologically advanced nations, to experience the illicit use of manufactured opiates; in contrast, where opium itself is produced and easily available its illicit use is of natural opium. For example in Western Europe and North America morphine, demerol, and heroin are often used; in southeast and southcentral Asia where opium is widely grown (either illicitly or without benefit of government control), prepared opium is smoked, eaten, or inhaled, and the use of heroin or morphine is secondary. In Asia changes in patterns of use are occurring. For example with the efforts at suppression of illicit opium production in Iran there has been an increase in heroin use. There, heroin use is, as might be expected, concentrated in urban young males whose pattern of use is to smoke it, as in traditional Iranian opium administration, rather than to inject it (Commission on Narcotic Drugs: Summary of Annual Reports of Governments, 1962). Mention is made of Iran only to demonstrate that patterns of illicit distribution and use of illicit opiates undergo constant change which are related to other changes, as for example in Iran to urbanization, agricultural land use change, and revisions in the law.

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[1] This is one of four papers prepared by Dr. Blum in collaboration with others on mind-altering drugs and dangerous behavior. The introduction to the series appears in the paper on dangerous drugs, printed in this volume as Appendix A-1. A third paper, on drugs, dangerous behavior and social policy, is printed as Appendix A-3. The fourth, on alcohol, is printed as an appendix to the Task Force Report on Drunkenness.

As an historical point, one relating to current opiate distribution, it is probable that widespread opium abuse, defined for the moment as disapproved or damaging use outside of conventional or institutionalized settings, is a relatively recent phenomenon, that is, one occurring only within the last 300 or 400 years. Early use of opium can be traced back nearly to 2000 B.C. (Kritikos) in the eastern Mediterranean where emphasis seems to have been on medical and religious purposes (Blum and Crouse).[2] However, one can presume idiosyncratic variations in use and the liklihood of individual dependency even in those times. Nevertheless widespread non-institutionalized or private opium use is verifiable only in later times, for example in China where by 1729 "abuse" was a serious enough problem to lead the Emperor to decree death to retailers (Lindesmith, 1965). Regarding manner of drug administration, it is interesting to keep in mind that the smoking of opium (or cannabis) did not take place until after the introduction of tobacco smoking; the latter occurring in the 16th and 17th centuries and constituting a worldwide epidemic (Laufer, 1924). Similarly the needle injection of opiates, as with heroin or morphine, awaited the technological development of the hypodermic needle in the 1840's. This point is made to show that diffusion of opiates depends upon other aspects of culture and social development, for example manufacturing and technology, as well as knowledge of various drug administration methods.

DEFINING PROBLEMS IN OPIATE "USE"

Before presenting the data on extent of American use, we must first deal with the matter of definitions of opiate "use." There are a number of ways to attempt to describe use and it will be seen, unfortunately, that one cannot be exact in the descriptions one sets forth. One may examine use in terms of its presumed purposes or settings, for example (*a*) opiates given on orders of or prescribed by doctors, (*b*) opiates taken for relief of pain as home remedies or in family medical care, (*c*) opiates taken privately (without any family knowledge or control) but with an ostensible medical purpose, as in the illicit self-medication of nurses and doctors with demerol, (*d*) and opiates taken without any ostensible medical or healing function, as for example the smoking of opium by a few Orientals and the use of heroin by city dwellers either in groups or privately.

It is quite clear that the presumption of purposes is not a fully adequate way to categorize use. One problem is that the ascription either of motives for use or of individual responses to a drug by observers is subject to dispute. A physician may take demerol because, as physician-addicts commonly report (Modlin and Montes, 1964), he is suffering fatigue or psychosomatic illness and needs the drug to carry on his work. The observer may disagree, saying the doctor is "escaping" and is reducing his capacity for effective work by taking a drug.

In the case of heroin the user may claim he is seeking "kicks" (euphoria), or that he wants to avoid the pain of withdrawal by maintaining his drug level. A medical observer might claim that the user's drug behavior is not euphoria seeking at all but is only a form of self-medication since it relieves the anxiety of an inadequate and immature person. With reference to the prevention of withdrawal pains yet another observer might note that these are likely to be mild indeed given the current dilution ("cutting") of heroin so that this claimed self-medication is but an excuse for continuing to seek pleasure or escape. In any event, inability to agree on opiate users' motives seems to be fundamental to some of the serious disagreements which have plagued students of narcotics use (and included among the students are the police, scientists, healers, and public policy makers).

If one were to discard attempts to categorize opiate use in terms of the stated or ascribable motives or goals of the individual user, and rather to base descriptions only on the actual results of use, one would then rely on "objective" measures, that is on statements by observers which can at least be subject to tests of reliability and consensus as in any scientific endeavor. The problems are several; one is that the statements of the individual drug user usually are considered as one measure of drug effects; for example when the heroin user says he "feels better" after taking heroin that is one measure of effects; when the observer rates that same user as suffering performance decrement, mental clouding, inactivity, and impaired social relations that is also a measure of effect—but a contradictory one.

Were one to require that the medical use of a drug not only be supported by claims of felt benefit (subjective reports) by the patient but proof of an actual change in health status as measured by physicians—including results of laboratory tests and the like—no solution to our problem is forthcoming. Typically in medicine the physician has aimed at the relief of patient distress with or without a cure of the illness; much "therapy" is but palliative in the absence of any means for bringing about cures. Whether one considers the symptom relief physicians seek for their patients by prescribing aspirin for headcolds, by administering tranquilizers to psychotic persons, or their giving of morphine to terminally ill patients, it is obvious that much accepted and humane medical practice rests only on results which constitute the relief expressed by patients, not in improvements in their physical condition. Even on these grounds, the production of relief, there is dispute about the actual effects of opiates. Beecher (1959) reports that the response to morphine of normal persons is dysphoria (unpleasantness) and that only a small proportion (about 10 percent) of a normal population will like what they feel under morphine.[3] It can be argued that medical use of opiates does not seek pleasantness but only relief of pain and that at least pain relief is a real and objective effect. Not so. Beecher's work suggests that physical pain as such, the sensations which are a central nervous system phenomenon, is unaffected by opiates; what is affected is the reaction, anxiety or "meaning" component of pain. Opiates reduce pain distress but not pain sensations; they do not raise the pain threshold. Indeed it is on these grounds that Beecher has argued that much present medical use of opiates is unwarranted, as for example in preparation for anesthesia. On these grounds also it is unwarranted to claim that the proper medical use of opiates be restricted to the relief of physical pain; it is not the physical pain but the way the person responds to and interprets his pain that is affected by opiates. For that reason any argument which seeks to categorize medical use as that involving demonstrable physical or even sensory effects alone is difficult to defend.

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[2] References are listed at the end of the paper.

One can, on the other hand, seek to define medical use not in terms of demonstrable physical effects of opiates, but by the kind of persons given the drug. For example, one might argue that only patients with demonstrable medical pathology constitute the subjects upon whom one seeks to demonstrate the efficacy of opiates and, thereby, legitimate medical use. At least two problems arise. One is that while the efficacy of opiates used to relieve pain in patients with organic pathology is demonstrable—that is, their distress is reduced—the opiates also produce side effects which are not efficacious. For example in the fine work of Beecher and his colleagues at Harvard, normal patients receiving morphine experience mental clouding, physical and mental inactivity, dizziness, nausea, itchiness, and headache. We can see that, as with any powerful drug, a variety of effects can occur simultaneously, some of them not effects one would seek. Efficacy then may be applied as a standard for medical use, but only if it is recognized that unpleasant and, with overdoses, dangerous effects will also occur, and that efficacy is reduction in felt distress. That statement brings the facts of medical use of the opiates closer to the problems and circumstances of their use by nonpatients in nonmedical situations.

The other problem which arises if one tries to limit the definition of legitimate medical use to the restricted population of patients with organic pathology is that much medical practice, especially office practice, does not establish the presence of pathology but is symptom treatment only. Essentially the doctor takes the patient's word for it that the patient has a cough or a pain in his belly or a splitting headache and treats him by aiming at symptom relief without the physician establishing—or proving with supplemental tests—the source of the symptom. Since much office practice handles psychosomatic, functional and routine psychiatric problems (see Blum, 1960), the prescription of opiates extends to a large number of people without demonstrable tissue pathology. Of these many will have physiological malfunction; many others will have psychiatric-psychological malfunctions without demnostrable physiological disorder.

This leads us to a present fact and a present problem, a fact which dictates the practical definition of medical versus nonmedical opiate use; a problem which is basic to current disputes both about the nature of the opiate user and to the best strategy for his handling. The fact is, that for very good and practical reasons, medical use is defined for purposes of nearly all reporting on the basis not of individual intention or goals of drug-taking (or drug-giving) nor on the basis of the results of that drug use, but rather in terms of the setting of use. If the setting is a sanctioned institution, a hospital, a doctor's office, a supervised university medical laboratory, then the use is medical. If the setting is informal, unsanctioned, not an approved institution where responsible and certified authorities are in charge, then the use is nonmedical and illicit. If the setting is halfway between, that is a family or home where drugs are available because of past prescriptions or nonprescripion drugstore purchases (as with codeine-containing compounds) then the present practical definition system breaks down—as do methods for counting users or anticipating addiction.

The setting which defines medical versus nonmedical use, and which for most purposes also describes legal versus illicit use, is of great practical convenience for purposes of tabulation. It also has great significance both in explanations or descriptions of the etiology (causes, history) of individual drug use and in disagreements about the causes of drug abuse and the proper handling of such abuse. It is likely (not yet a fact but as a reasonable hypothesis) that the settings in which drugs are used are associated with and predictive of the kinds of individual drug-using behavior which will evolve. People who take any mind-altering drug are much affected by the situation in which it is used (Beecher, 1959). Research to date (Blum, 1964; Lolli and Silverman, 1965) indicates that when drug use begins and is learned within approved and controlled settings and continues in those culturally integrated settings, individual variability in response to drugs is low (that is most people can be expected to act in the ways the institution expects them to act) and abuse is not a concern (if for no other reason than that the operations of the institution are already approved by society). When institutional controls are removed and drug use is not integrated, either socially or in terms of personality, then much individual variation can be expected, safeguards and protections for the individual are missing, and disapproval for irregular behavior leads to judgments of abuse. One cannot, however, assume that the setting causes the pattern of drug use which can be predicted from the nature of the setting. People come to settings—or are born in them—so that their social circumstances dictate how they will begin and continue to employ drugs. People with psychological problems—or problems in living, as they can be called (and the latter includes all of us)—who look at how they feel and decide they need a doctor are different from those people who feel distress and decide (again volitional terms are inaccurate) to "raise hell" or "get drunk" or to "mainline." The former and the latter groups come from differing social as well as personal backgrounds. People who think in terms of doctors and approved ways of relieving pain, people who have access to doctors and know how to get along with them and who are capable of cooperating with them in care are socially and psychologically different from people who don't define their troubles as "inside themselves," the people who don't have awareness of or access to medical care, or who don't know how to utilize that care once they have it. Nevertheless, both kinds of people may feel distress and seek some drug to relieve it; both kinds may feel dissatisfied and experiment with solutions offered by their peers or by older authorities.

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[3] It is of interest that both normal subjects and chronically ill patients report that the amphetamines are much more pleasurable than morphine or heroin. Most addicts, on the other hand, enjoy morphine more than amphetamines in the Beecher studies.

As a general statement, one not applicable to all groups or persons but constituting an overall picture, the people who choose or follow respectable channels—including medical care—for solving their problems or exploring new experiences or simply being alive are better off in the first place, "better off" in the sense of their economic position, education, and personal psychological and physical health. The persons who are simultaneously most underprivileged and most subject to social stress appear to be the urban poor. Among the urban poor one finds high rates of physical and psychological ill health, little knowledge of ways to better that health, limited access (by virtue of their own reluctance and ignorance, difficulties in transportation, insufficient funds to pay for care, inadequate communication with physicians so that they learn less and get less in medical care, etc.) (see Blum, 1964) to better care; and simultaneously high exposure to other strains. It is in this group of urban disadvantaged folk that one finds most of the events with which the President's Commission is concerned; street crime, recidivism, inequities in the operation of the administration of justice, and flagrant drug abuse. There are, as our attention to epidemiological studies will show, important variations within the urban poor that are associated with the differing patterns of opiate use; nevertheless the kind of use that is linked to crime will be seen to be part of a constellation of other pervasive social, economic, and psychological disadvantages.

In discussing kinds of opiate use we have seen that the setting of opiate use, medical or other, approximates the legal definition of use; that is, legal or illicit. One must say "approximates" because within the medical setting illicit use has also been noted, typically in the self-medication of medical personnel or in the home or private use of opiates which, once prescribed or medically recommended, become objects of dependency as in the use of codeine, paregoric, morphine, etc. There can also be illicit medical use in which the prescribing physician rather than the patient is judged to behave illegally. The closing of narcotics-dispensing clinics in the 1920's presaged a series of later court decisions, not the subject of this report, in which physicians have been found guilty of illegally prescribing drugs. Discussions relating to prescription crimes may be found in Lindesmith (1965), Eldridge (1962), and the Interim and Final Reports of the Joint Committee of the American Bar Association and the American Medical Association on Narcotic Drugs (1962). On the other hand, the nonmedical use of opiates is not always handled as a criminal problem. As in any form of police activity, the discretion of the officer may be employed to direct an apprehended person into medical or other channels for attention without formal arrest and booking. Testimony by Federal narcotics officers (cited in Lindesmith, 1965) indicates that they, like other law enforcement personnel, have utilized these other community resources for informal offender referrals. It appears generally to be the case (see Skolnick, 1965) that a nonmedical opiate user may not be prosecuted upon apprehension when he agrees to serve as an informant helping the police to track down drug sellers or when the user appears to have personal and social qualities suggesting his capacity for benefitting from nonpunitive handling. That these qualities (e.g., a history of social adjustment, integration in the community) are usually associated with higher social position (as in physicians, businessmen, or other elites) has distressed some observers who lament the differential enforcement of the law, favoritism, or suspect corruption. The differential handling of offenders is sociologically no more unique than the differential handling of other clients of professionals who make judgments about suitability of one or another procedure which are linked to the social characteristics of the client in relation to the characteristics of the authority making the judgment. Psychiatric patients, for example, receive differential treatment (Hollingshead and Redlich) from psychiatrists depending on their social class. Differential police handling of opiate users—criminal charges for some and informal disposition for others—can be unjust practice in terms of the law and democratic ideology. However, when it occurs it cannot be automatically assumed to be either a prejudiced or favoring act nor can it be assumed that the officer is necessarily incorrect in predicting—and a prediction is inferred from his actions—that one man sent to a doctor or referred to his family will respond better than the other whom the officer decides to arrest. It might be well, at this point, to cite the finding by Wilson (1963) comparing an eastern and a western police department. He found that the more "informal" and "corrupt" eastern department prosecuted and sent fewer delinquents to jail—instead encouraging informal community control efforts—whereas an exceedingly modern, "just" and "honest" western department relied more heavily on prosecution and incarceration; the latter not necessarily being the procedure of choice with youths if one seeks to abort emerging criminal careers. The failure to reach a consensus about the standards employed in differential handling has led to serious and disruptive dispute between the police and their critics. Better communication and a shared problem-assessing approach seem to promise solutions whereas continued accusations by people in fixed positions on either side do not.

The problem of the discretionary handling of opiate offenders is not only important in terms of the ideals one has for law enforcement or for correction, but contributes to inexactness when one tries to assess the extent of opiate use. No one has ever counted the number of persons using opiates legally; there are many counts of offenders arrested for illicit use. Since some persons apprehended for illicit use are handled in a discretionary fashion, not becoming a statistic, the tabulation of users becomes less exact. Since there is some middle ground as well—and this in spite of the most careful efforts by narcotics enforcement personnel to monitor opiate importation, manufacture, and distribution through legal medical channels—where medical users might qualify in court as offenders another group is also lost to the count.

Other difficulties must be mentioned in the matter of setting up categories of opiate use. An individual may use an opiate without knowing he is doing so; typically medical patients receive drugs the content of which is unknown to them. Lindesmith in an early work (1947) suggested how some of these patients could become addicts when they were told that their withdrawal distress, which they had not been able to diagnose, was due to morphine withdrawal so that these patients came to look at themselves as addicts. Regardless of the frequency of such surprise addictions, a count of use cannot assume that all opiate users—and even dependent persons—are aware of what they are taking. Indeed even with the protection brought about by pure food and drug laws, many home remedy users might be surprised to learn that their favorite remedy contained 20 percent alcohol, or caffeine, or some other drug with central nervous system irritating or dependency-producing potentials.

When one speaks of use one must also specify when, how much, and over how long a time. Is an opiate user one who takes Percodan whenever she has menstrual pain, not knowing it is an opiate, her self-medication occurring perhaps no more than once every several months? Is a user someone who tried heroin once 10 years ago? When we speak of use are we speaking of any use, a one-time incidence, over a lifetime? Or shall we limit ourselves—if ever one has the chance to make an accurate count—to current use? And with current use do we require chronic administration or do we include the occasional user? These questions of counting plague every drug-use study; they do not complicate most contemporary narcotics statistics only because our present counting methods are so limited that we are fortunate to get any notion of the size of the population of opiate-dependent persons and must accept inexactness as a condition of our present development. We have some knowledge— in that we are better off than many nations. Our inexactness, although unfortunate, should not be the subject for accusations or recriminations—as now occurs between some bureaus, some scholars, and some law enforcement personnel—but a challenge for improvement.

There has been no national survey of opiate use; there is no count made of individuals receiving prescriptions containing opiates. There are careful counts made of the number of opiate-containing prescriptions given, excluding some of the mild opiates and with State-by-State variations. There are careful counts made of the number of persons arrested under narcotic statutes, these arrests being classified by the kind of drug employed. These arrest by drug figures focus on the drug associated with the offense at the time of the arrest; they do not focus on the offender and his entire pattern of drug use. Consequently a count which cites one heroin addict might be referring to a person who characteristically uses heroin, cocaine, methedrine, and marihuana but who at the time of his arrest possessed heroin for which he was charged.

There are national counts of addicts which report the number of past offenders reappearing as offenders and which record the number of new addicts. These national counts do not, as we shall see, agree with State figures. The reasons for this inconsistency may be many, but it is reasonable to assume that the same problems which bedevil crime reporting generally afflict the narcotics statistics. Local departments differ in the adequacy of their recordkeeping and the procedures which their records reflect differ drastically. Final arrest data reflects unreported attenuations due to discretionary handling, changes in the charges, etc. The definitions of kinds of cases and kinds of offenses differ and are capable, even when one strives for a standard, of varying interpretation. The purposes for which statistics are kept differ and are reflected in summary reports. These problems in crime statistics are well-known to all who work in the field. One scholarly effort to demonstrate a new reporting system (not for drug offenses) is represented in the work of Wolfgang and Sellin (1965). Other task forces of the Crime Commission as well as a number of Federal, State, and local law enforcement agencies are working hard to improve crime counting methods.

One special problem in narcotics statistics is based on a category of use which defines the characteristic drug pattern of the using person, namely the addict. Many systems of criminal statistics rest on this classification even though the term does not intrinsically refer to an offense as such (the courts have ruled it is not illegal to be drug dependent) and there has been so much difficulty in defining the term medically and psychologically that the World Health Organization Expert Committee on Addiction Producing Drugs (13th Report, 1964) has recommended international abandonment of the term in favor of speaking of drug-dependency qualified by the type of that dependency. The World Health Organization for example describes drug dependence of the morphine type as occurring when the following conditions are found in a person: (1) "An overpowering desire or need to continue taking the drug and to obtain it by any means; the need can be satisfied by the drug taken initially or by another with morphine-like properties, (2) a tendency to increase the dose owing to the development of tolerance, (3) a psychic dependence on the effects of the drug related to subjective and individual appreciation of those effects; and (4) a physical dependence on the effects of the drug requiring its presence for the maintenance of homeostatis and resulting in a definite, characteristic, and self-limited abstinence when the drug is withdrawn."

Many persons who take morphine would not develop all of these characteristics and would not, consequently, be considered to have an opiate drug dependency. Chein, Gerard, Lee, and Rosenfeld (1964) in their comprehensive study point out that many persons admitted and treated as addicts use heroin only irregularly and experience only very mild withdrawal symptoms. These investigators themselves distinguish three dimensions of addiction: (1) The degree of physiological dependence, (2) the extent of personal involvement with narcotics (importance in life and social activities), and (3) the extent of the craving—being a desire for getting "high," that desire intensifying the longer the time after the last narcotic use or intensifying when the person is under stress (the overpowering desire of the WHO definition). Given these elements Chein, et al., distinguish four types of addicts: (*a*) Persons totally involved in the drug world but who do not experience craving, (*b*) persons having craving but without total involvement (in the drug milieu), (*c*) persons having both craving and total involvement, and (*d*) persons without either craving or involvement but who nevertheless use narcotics. These writers include a drug-use-over-time component in their definition of the addict, requiring a history of dependence (dependence presumably being very close to addiction and thus introducing a certain awkward circularity in their classification process). In any event persons with a one-time dependence are not classified as addicts, a requirement which does make the diagnosis of addiction dependent upon the life history of drug use.

An English group working on addiction (Robertson, and Walton, 1960) concluded after an extensive review of the literature on addiction that the only workable definition which would allow all of the scientific findings to be included was essentially a role-taking one; that is, an addict is anyone being treated for addiction by a physician. That definition would exclude large numbers of persons arrested as addicts but not given medical treatment.

The definitions offered for addiction by the medical-scientific community can be complex ones involving several components in the person of the drug user and based on a clinical appraisal of the user. The conclusion of Chein, et al. (1964, p. 348) illustrates this position, ". . . opiates are not inherently attractive, euphoric or stimulant substances. The danger of addiction to opiates resides in the person, not in the drug." Personal behavior and history determine the diagnosis rather than does the fact of arrest based on the evidence of acquisition, possession, and the inference of use of a drug. Since law enforcement statistics rest on the latter and scientific discussion on the former, there can be considerable debate and confusion when persons with these differing definitions exchange views about addiction. Within the law enforcement field, as within the scientific-medical one, there is internal disagreement over classifications and diagnoses; as in most fields of human endeavor insiders disagree among themselves as well as with outsiders. Disagreement does not imply that one faction is right and the other wrong; it is likely instead that it represents efforts at the solution of various problems which reflect the differing backgrounds of and tasks facing the persons charged with reporting.

The Bureau of Criminal Statistics of the State of California has been working diligently to improve drug-crime reporting. They have recognized the problems inherent in the traditional statistics on addicts based on reported arrest-by-type-of-drug rather than personal characteristics or instead of on simpler reports of offenses without implications about the general behavior of the offender as is assumed with the use of the term, "addict." A criminal statistics expert (Bridges, 1965) has stated that, "The term 'addict' is probably one of the most misused and misunderstood terms in the field of law enforcement. * * * the term addict is nonspecific and its meaning depends on the background of the person who tries to comprehend the sense intended." Bridges considers it impractical, from the standpoint of criminal statistics, to distinguish addicts by frequency of use or personal traits in the sense of a medical diagnosis of addiction. He does indicate the practicality of breaking down narcotics to exclude marihuana and hallucinogens and to qualify the definition of an addict in terms of the drug employed. The classification system of the California Bureau of Criminal Statistics (CBCS) does rest on the stated premise that drug users may show variation in kinds of drugs used, but that once identified as a narcotic (essentially the opiates and cocaine) user it is assumed his use pattern will continue to employ these substances so that later arrest for the use of other drugs do not lead to his narcotic-user category being changed.

The CBCS in partially abandoning the addict classification has introduced the term "addict-user" instead to mean one (based on life history grounds) who has periodically or habitually used heroin or some other narcotic. The addict-user is further categorized either as active, potentially active, or inactive. An active addict-user is one who has a drug arrest during a given timespan (at present the 5-year 1960–64 period). This is the same definition of active employed by the Federal Bureau of Narcotics. Potentially active users are those with arrests in one time period not followed by arrests in another; at present in the CBCS system that means a 1959 arrest but no drug arrests during 1960–64 because they were during that time confined in institutions or deported; circumstances preventing them from drug rearrest in California. The inactive classification is made up of 1959 drug-arrested persons who show no further drug arrests and were not incarcerated (at least for long periods) during the 1960–64 period. The CBCS system is an effort to accommodate offense reporting to personal drug use patterns over time. Their provisional system demonstrates another way of reporting drug use.

THE EXTENT OF OPIATE USE IN THE UNITED STATES

MEDICALLY PRESCRIBED USE

It is possible to estimate the number of individual doses of opiates ordered or prescribed by doctors during the course of one year. The Bureau of Narcotic Enforcement of the State of California (personal communication), using 1964 FBN statistics, resting estimates on standard dosages, arrives at the following figure for medically offered opiates for the year 1963.

Drug	Average dose (mgm)	Doses sold to hospitals, pharmacies, and physicians in calendar year 1963
Medicinal opium	60	31,583,333
Morphine	15	41,533,333
Dihydromorphinine (dilaudid)	2	25,500,000
Oxymorphone (numorphan)	1.5	8,666,666
Ethylmorphine	15	4,266,666
Codeine	30	491,466,666
Dihydrocodeine	30	1,733,333
Dihydrododeinone (hycodan)	5	83,000,000
Oxycodone (percodan)	5	120,500,000
Pethidine (demerol)	50	200,180,000
Anileridine	25	10,920,000
Methadone	5	17,000,000
Alphaprodine (nisentil)	60	633,333
Levorphanol (levorphan)	2	4,000,000
Piminodine (alvodine)	50	3,080,000
Total		1,043,663,330
Cocaine	30	1,436,666

From the table, which is only an approximation of actual doses dispensed, one can see that codeine is most often ordered or prescribed, followed by Demerol and Percodan. The total number of individual doses of opiates (excluding cocaine) legally ordered or prescribed during 1963 in the United States approximates 1,043,663,330! On a per capita basis that means about five and one-half doses of opiates for every man, woman, and child in the country. Since it is to be assumed that medical opiate use is not equally distributed in that fashion, but rather is concentrated on sick persons and, among the sick only among some patients, one presumes that some far fewer persons receive a much higher individual series of opiate prescriptions (for drugstore filling) or orders (in M.D.'s office and hospital dispensing).

It would be very interesting to know what number of individuals do receive opiates medically and how much they receive. It would also be interesting to be able to distinguish outpatient use from administrations within hospitals or doctors' offices. It would also be well to know how much of the opiate dosage is used at Lexington and elsewhere in treatment and research on addicts. A rough estimate of the predominance of office and hospital drug administration as opposed to drugstore outpatient prescription filling is to be derived from State of California triplicate narcotic prescription records which show 338,865 opiate prescriptions for 1965–66, or one prescription for about 2 Californians out of 100. The triplicate reporting excludes codeine compounds such as empirin-codeine (APC with codeine, etc.). Assuming that the per capita rates derived from the table do apply to California, then how does one reconcile triplicate records showing less than 2 percent receiving outpatient opiates as opposed to the table-derived estimate of five plus doses for 100 percent of all citizens? The table, of course, includes codeine, nearly half of all opiate doses in fact, and that is excluded from California triplicate records. Excluding codeine from our calculations, one still gets a triplicate incidence of 2/100 as opposed to a table-derived incidence of 250/100. (Which also would mean that incidence of codeine use is 250/100.) Triplicate records are limited to outpatients; the table-derived figures include all opiates distributed to doctors' offices and to hospitals. One is forced to conclude, without having any good reason as yet to trust the conclusion, that with the possible exception of codeine, most opiates are distributed under direct medical supervision rather than on a prescription basis. If one further assumes, again more for the sake of estimates than on the basis of knowing, that most supervised medical use occurs in hospitals rather than in doctors' offices, then one can begin to estimate the actual opiate use by ill persons. Each year 8 out of 100 Americans go to the hospital (Blum, 1964). If one assumes the equal distribution of all opiates (including now codeine which is used in hospitals primarily orally in APC ["empirin"] codeine compounds) to all hospital patients, then one finds medical opiate dispensing concentrated among the 22,500,000 or so hospitalized Americans; or perhaps more heavily concentrated among the 6 out of 100 undergoing surgery plus terminally ill patients in pain. If medical opiates are primarily limited to hospitalized patients, then the average patient would receive about 45 opiate doses or, excluding codeine completely from consideration, perhaps 22 strong opiate doses. Given administration every 4 hours, for 16 hours a day, that means about 5 days of hospital opiate administration per patient. If one narrows the estimated population to the surgical 6 out of 100 then each patient in that group would receive 96 doses or, excluding codeine, upwards to 50 doses over perhaps a 10- to 12-day period.

The foregoing are conceived as speculative exercises in the absence of facts. The intent is to suggest that some Americans do receive large doses of opiates medically. Since not all those receiving frequent opiate doses are likely to be terminally ill patents who die and cannot become addicted therefore, and since one assumes that the number of patients receiving heavy doses exceeds the number of persons reported as medical addicts,[4] one is led to suggest that (*a*) some proportion of persons who receive sufficient opiate doses to become addicts, i.e., dependent, were the drug alone the cause of dependency do not in fact become dependent, and (*b*) some proportion of persons receiving opiates medically may become dependent without ever being identified as having a drug abuse problem. The implications are (*a*) that heavy opiate use over a period of time in a medical setting does not lead to addiction because factors other than the drug itself are necessary for addiction, (*b*) that persons may be drug dependent without bringing attention to themselves in other ways and may thus get along as relatively normal members of society, and (*c*) we are much in need of information about the actual incidence of opiate use in the United States.

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[4] To test such assumptions it would be good to have information about the number of patients reported as medically maintained opiate users, persons who are medical addicts whose use is legitimated by the presence of concurrent organic pathology. The FBN does not have such data nationally, and on the State level such reporting is inadequate to allow real population estimates. For example, in California the law requires physicians to notify authorities when they dispense opiates to a person chronically using them. Physicians may or may not so notify and further the State files of such persons are not purged of persons who die, or whose drug use is terminated. For enforcement purposes no such file purging is necessary. One sees that the needs of a public health or sociological headcounting statistical system differ from those of law enforcement groups.

One pilot study (Blum, Braunstein, Stone) has been done which sought reports of opiate use from a representative sample in a California metropolitan region. The sample size was small (N=200) so that a larger than desirable error of estimate is introduced; sampling methods were also less exact than one would wish for. The study found that 67 percent of the adults interviewed said they had used medical opiates; of these 67 percent past medical-opiate users, 10 percent said they were now using these drugs occasionally, 5 percent said they were using them regularly. These survey figures of experience and present use are consistent with the dosage inferences derived from the table; they are not consistent with the triplicate reporting outpatient figures for California of less than 2 percent receiving opiates during the same time period as that described by survey respondents. The discrepancies can be reconciled by assuming that much of the respondents' regular use was of codeine-containing compounds not covered by the triplicate reporting. In any event, both the estimates derived from the table and those from the survey suggest the possibility that regular opiate use can occur without any medical or legal identification of the user as an addict. This is not to presume the presence—or absence—of drug dependency, but only the absence of behavior aberrent enough to bring the user to the attention of others.

ILLICIT OPIATE USE

There is no data on the frequency with which illicit users have used opiates during any given time period nor is there data on the actual dosages used. Since illicit use is of "cut" or diluted materials, reports of users, even if sought, cannot be accurate. Since imports for illicit use cannot be known, even if hopeful estimates based on extrapolations from sizes of seizures are set forth, the quantities of illicit opiates involved remain an unknown. When one focuses on known users defined in conventional statistics as addicts, statistics are available. As of December 1965 the Federal Bureau of Narcotics reported (tabular summaries, 1966, unpublished data) 57,199 active addicts in the United States. An addict is anyone arrested for the use of opiates or cocaine during the period 1960–65.

Federal Bureau of Narcotics summaries have been criticized (Lindesmith, 1965) as underreporting offenders. Bridges (1965) from the California Bureau of Criminal Statistics (CBCS) compares California State statistics on the number of new addicts as reported by the FBN (Federal Bureau Narcotics) with addict-users reported by the CBCS. The FBN listed 697 new addicts for 1963 and 691 new addicts for 1964. For the same period the CBCS reported 2,434 addict-users in 1963 and 2,310 for 1964. A total FBN count for addicts in California for 1964 is 6,624. The CBCS figure for active addict-users is 17,727, and for addict-users in toto, 18,251. CBCS attributes the difference to more limited information received by the FBN than is available to CBCS.

National estimates by others generally reflect larger figures than those reported by FBN. These range up to 200,000 active addicts (Lindesmith, 1965). There is no present way to verify any of the estimates; were the ratio of FBN statistics over California BCS statistics to hold nationwide, a ratio of FBN underreporting at about one-third, then those who claim 180,000 active opiate addicts might be correct. In the final analysis it must be understood that no exact figure will be, or need be, achieved. The opiate addict population is continually changing, and each casefinding method builds in its own limitations and sources of bias.

If we turn to the inadequate pilot population survey earlier cited for one California metropolitan region (Blum, Braunstein, Stone), one finds a lifetime experience with illicit opiates including cocaine (one or more doses) reported by 4 percent of the population but active use, defined as regular or occasional present use admitted by none of the population interviewed. The chances are 99 out of 100 (in terms of statistical probability) that the actual active opiate-cocaine use in that metropolitan area does not exceed 1.82 percent and is, of course, likely to be much less than that. Thus there is verification of a very limited sort for the conclusion reached by the analysis of any set of criminal statistics and medical prescription data on opiate use to the effect that not only are the number of arrested opiate offenders small, but the number of nonmedical and potentially arrestable illicit opiate users is also small viewed as a proportion of the total population. In terms of the present number of addicts who have been arrested for opiate use within the last 5 years that number probably does fall below 200,000. That means that the number of adjudicated opiate offenders is less than 1 per 1,000 population.

EXTENT OF USE: SUMMARY AND COMMENT

On the basis of law enforcement statistics it is clear that not many Americans are engaged in opiate use of the sort that has led to their identification as illicit users, less than 1 per 1,000 are so categorized. On the other hand, data from various sources suggest more have experimented with what would be illicit use (if apprehended and charged) without becoming either addicted or identified. If we take the inadequate survey data as a top figure, perhaps up to 4 percent of a metropolitan center population have experimented without getting in trouble. Medical opiate use is, on the other hand, widespread. More than enough doses are administered each year to allow every American to receive opiates; the chances are that many if not most citizens have had opiates when ill; furthermore in any given year patients getting opiates receive enough to become addicts were addiction to be the normal response to opiate administration. Those who are—at any one point in time—regular medical users of opiates are more prevalent, if we refer to the survey data, than had been thought; the inadequate survey shows 5 percent. Assuming, as a guess resting on available information, that between 50 and 75 percent of all adult Americans have been exposed to opiate use in some setting, but that only 1 in 1,000 Americans is an illicit (active) addict, one calculates that the maximum chance of becoming an addict simply on the basis of opiate exposure alone is about 1 in 500. As we shall see, the risks vary considerably depending upon socioeconomic and personal circumstances. Thus for medical patients the risks are much lower, while for New York City slum delinquents, the risks are much higher.

The inference to be drawn is that opiate use is itself a widespread and "normal" phenomenon and that opiate use associated with medical care results in very few persons being identified as problem users even though the possibility of hidden dependency exists for some. Illicit use, defined as a nonmedical introduction to opiates, is uncommon but far more persons try opiates in illicit settings than become opiate dependent or become identified as addicts. To be exposed to and use an opiate as such is not unusual. What is unusual is to behave in such a way afterwards that dependency develops or that one is identified, as a consequence of one's behavior (or bad luck), as an addict.

CHARACTERISTICS OF USERS

Addiction has attracted a great deal of scientific attention and much work has been done describing the social and personality characteristics of opiate users. At the outset it must be kept in mind that the social characteristics of opiate users change over time so that any descriptions are best limited by the caveat, "here and now." For a review of the literature up to 1951 describing addict characteristics, Meyer (1952) is an excellent choice. There is inadequate data on characteristics of the opiate user in the early part of this century prior to the passage of the Harrison Act. Kolb (1962) reports women outnumbered men as addicts in the 19th century. After patent medicines and other opiate preparations were forbidden, the population of users was altered and men came to predominate. Early in the century Chinese-American opium smokers constituted an important number of illicit addicts. By 1965 there were no more than a few hundred Orientals using any kind of opiate according to FBN data.

FBN ADDICT CHARACTERISTICS

FBN active addict data (1966 summary tables, unpublished) now shows that more than half of the identified opiate offenders are Negro (51.5 percent), that about 13 percent are Puerto Rican, and that 5.6 percent are of Mexican extraction. The Negro and Puerto Rican ethnic groups are overrepresented among addicts in contrast to their numbers in the total population, the Mexican-American are not.[5] Whether their prominence in FBN statistics reflects vulnerability to arrest or vulnerability to illicit opiate use per se cannot be settled on the basis of criminal statistics themselves. FBN statistics also show age categories for addicts; the modal age group is 21–30 which contains 46.5 percent of all active addicts. The age group 31–40 contains 37.7 percent of the FBN addicts, the age group 40 and over contains 12.4 percent, the age group 18–21 contains 3.2 percent and the 17 and under group contains 0.02 percent. FBN identified addicts are younger people and predominantly males (81 percent in 1962).

LEXINGTON USPHS ADMISSIONS

Another population of identified opiate users are persons admitted to U.S. Public Health Service hospitals for addiction treatment. In 1963 Lexington hospital addicts (Ball, Bates, and O'Donnell, 1966) were primarily males (85.8 percent), young adults (50.3 percent under age 30) with an average age of 32.9 years, and about one-third (35.3 percent) were Negroes. Most patients came from a few States, New York leading with 30.2 percent residing there, with Illinois (14.2 percent), Texas (8.5 percent), New Jersey (5.5 percent) and California (5.1 percent) following. Considered in terms of rates of admission over State populations, New York leads followed by Puerto Rico (a Commonwealth, not a State), Illinois, Texas, New Mexico, New Jersey, Alabama, Arizona, etc. The District of Columbia had the highest rate of admissions (19.3 per 100,000 adult population) which is in keeping with its entirely urban character. Addicts were predominantly metropolitan by place of residence; over 90 percent of all patients were from areas of over 50,000 population. Nearly half of all patients came from only two such regions: New York-New Jersey and Chicago. Comparing recent admissions to Lexington (1963) to those admitted in 1936 it is found (Ball, and Cottrell, 1965) that population characteristics are changing; recent admissions are younger, more often come from large metropolitan areas, and are more likely to be Negroes.

CALIFORNIA CRIMINAL STATISTICS

Another population of police-identified addicts is represented in California BCS tabulations and in studies made of patients received in the California (narcotics) Rehabilitation Center. In California user-addicts were predominantly white (about 50 percent), with Mexican ethnic group members accounting for 37 percent and Negroes 19.6 percent. Almost 83 percent were males, 17 percent females. Almost no user-addicts were under age 18. In 1964, over half of the California offenders were under 26 years of age at the time of the first narcotics arrest. Over 25 percent were over age 40, an important point to consider in view of data from other sources showing little illicit opiate use after age 40. Over a period of 5 years the median age of addict users has remained constant at 27. This means that there is no trend data showing the increased opiate use of either younger or of older persons in California over a 5-year period. Statistics from the California Rehabilitation Center are in keeping with the general arrest statistics;

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[5] In 1960, 5.2 percent of the total population were Spanish-Americans.

87 percent of the admitted inmates were men, the average age was 27.

PHYSICIAN ADDICTS

It should be clear that the picture of the gross characteristics of opiate defenders derived from criminal statistics is a composite; within the population are a variety of subgroups each with its own special features. An interesting group of opiate users are physicians since they come from backgrounds quite different from those associated with the youthful underprivileged user. It is claimed that medical personnel face opiate use as an occupational hazard. Pescor (1942) for example found physicians to be overrepresented among Lexington patients by a factor of eight. Eldridge (1962) says medical personnel are addicted at a rate 30 times higher than that expected from normal population figures. Modlin and Montes (1964), reviewing a variety of reports say that in the United States and in Western Europe physicians account for about 15 percent of all known addicts and that another 15 percent are members of paramedical professions; a total of 30 percent being drawn from medical professionals. Modlin and Montes rely on a variety of sources including estimates and small sample studies; their final figure may be correct but in the absence of better head-counting procedures (speaking figuratively as well as literally), the estimate should be viewed with considerable caution. Certainly the evident presence of health professionals in the opiate-dependent population does point to a critical fact about drug abuse; availability of the drug is a necessary condition for dependence and easy availability along with an acceptance of drug use as an appropriate activity (which must characterize medical professionals dispensing pharmaceuticals in their work) is a precondition for the development of use. The choice of drugs by medical-paramedical personnel is consistent with their work opportunities and knowledge; demerol is said to be the primary opiate abused. Earlier medical emphasis was on morphine; a point made by Meyer (1952) in his observation that heroin is a lower class drug whereas morphine and similar substances will be employed by higher status persons. That the choice of particular forms of a drug does vary by class and subculture is well known (see Carstairs).

The studies of physician addicts are useful in emphasizing some of the personal features associated with dependence in an otherwise advantaged group. Contrasting physician addicts with other Lexington patients, Pescor (1942) found the physicians to be older, more often a voluntary admission, began drug use later in life, began using drugs for relief of pain rather than curiosity or because of their social milieu, limited themselves to morphine, had longer addictions, had prior effects at voluntary cures, relapsed more often to alcohol and not in association with other addicts, had much later first arrest ages, were from better families and had higher education, and were less often from metropolitan areas. Physician addicts were able to procure drugs to support their habit while continuing work, were happily married, brighter, and upon release were more easily integrated into the community; in spite of all this Pescor in a follow-up study found as high a relapse rate as among underprivileged opiate users. Putnam and Ellinwood (1966) studying Lexington physician-patients in contrast to control doctors found the addicts to have moved more often and to much more often drop from medical practice; even so, many were able to maintain their marriages and medical practice. Modlin and Montes (1964) in a recent study of physician addicts treated at the Menninger Foundation found most to use demerol in addition to a variety of other mind-altering drugs including alcohol (this multihabituation was also found by Putnam and Ellinwood). They became addicted at an average age of 38, had fathers who were heavy alcohol drinkers, had sickly childhoods, felt distant from their fathers and critical of their mothers, were studious as adolescents and had poor marriages with poor sexual adjustments. Their stated reasons for starting narcotic use included overwork, chronic fatigue and physical disease. They were men who were overworked, say the investigators, because they had average abilities and unrealistic goals; their fatigue represented not only overwork but neurotic conflicts and basic ambivalence toward medical practice. These physicians had magical beliefs about the non-addictive properties of drugs and of their own invulnerability. They were "oral characters" who were interpersonally dependent (on wives and mothers) prior to becoming dependent on drugs. Addiction was a symptom of progressive personality disorganization with early poor parental relations and illness, later discouragement with work and inability to adjust to marriage and parenthood, and continuing illness. Upon arriving near midlife they were disillusioned and could anticipate no future fulfillments; they therefore turned to drugs for the gratifications not found in life.

OTHER USER CHARACTERISTICS

As indicated above, exposure to risk differs by occupation; it also differs by place of residence, social class, age, and other sociocultural factors. Among persons exposed to risk, i.e., having the opportunity to take drugs in an environment where others take them, use will be higher. So it is that medical personnel, patients being given opiates, persons living in delinquent areas in contact with criminals and opiate supplies, and persons in certain occupations with traditions of opiate use (entertainment, prostitution, etc.) will be expected more often to develop use and also dependency. Use and dependency are of course not the same; within groups exposed to risk and among persons initiating drug use, only some will become dependent. These latter will be seen, in studies soon to be cited, to differ in terms of associates, personality, interests, and family background.

Robertson and Wa[illegible] (1960), reviewing worldwide studies, suggest that the age of addiction onset to opiates most commonly is 21–30. The average onset age may change with time; Finestone (1957) shows how in the United States identified opiate violators are younger in certain regions in recent years; for example in Chicago in 1934–38, persons aged 16–20 accounted for only 0.43 narcotic violations; in 1951 they accounted for 13.65 percent. This finding is compatible with Maurer and Vogel's material (1954) and with the earlier cited data from Lexington showing decreasing age of admissions; the same trend on the other hand is not visible in California for opiates emphasizing that age differences in turn reflect other social events.

Ethnic characteristics also appear to be expressions of other sociocultural forces operating to produce exposure to use and vulnerability to dependency. One can compare the FBN data showing high Negro offense rates with the California CBS data showing low Negro offense rates. Clausen (1951) emphasizes the increasing proportion of Negroes in the addict population; in Chicago Negroes now constitute the majority of identified offender-users. Studying juvenile (16–20) heroin use in New York City, Chein *et al.* (1964), found neighborhoods differ dramatically in their proportions of heroin users. Twelve of fourteen high-drug neighborhoods contained over 70 percent Negro and (not or) Puerto Rican groups which were characterized by poverty, poor education, disruptive families, high crowding in housing, and so forth. Within any ethnic group users were found to differ from nonusers on a number of personal and family features showing that resistance to use as well as vulnerability must occupy the attention of those interested in drug diffusion. In another city, Vancouver, B.C., Stevenson and his colleagues (1956) have shown that addiction is primarily a Caucasian phenomenon; that, in spite of the presence of large numbers of Chinese and Amerindians in the city. Within a Negro slum population, Finestone (1960) has shown how the use of drugs functions to meet the particular social and psychological problems facing the drug-exposed population. His findings, as others, stress a point which must not be missed; that an ethnic group is not predisposed to opiate use by virtue of any inherent racial or ethnic criminal culture or weakness. Rather it can express an attempt at personal adjustment—or a personal reaction to maladjustment—which also has certain meanings or symbolic value for the using group. The opiate dependent behavior of the underprivileged is a response of persons to forces generated outside their ethnic group; not an "invention" of that group which is simply criminal or rebellious, as some minority group critics have suggested.

Residence for most opiate addicts is, as Lexington statistics show, in poor metropolitan areas. As Chein *et al.* (1964), and Rosenfeld (1957) have shown in New York City, these neighborhoods of high-opiate addiction are the most deprived areas where a delinquent orientation to life exists comprised of pessimism, futility, mistrust, negativism, defiance, quick pleasures, exploitation of others, etc. Even in heavily criminal neighborhoods these adverse attitudes may not be held by the majority of residents, but by a sufficient number to provide a philosophy—or at least a set of rationalizations—to the growing youngsters whose family background and personality make them potential recruits to delinquency. The heavy heroin-use neighborhoods in New York City are also characterized by broken families, an excess of adult females over males, unemployed men and working women, low educational levels. One infers that the black ghetto neighborhoods in which Finestone (1960) made his observations in Chicago are much like the unwholesome New York heroin-using centers. Clausen's (1957) descriptions of Chicago are similar.

Education. When sampling from addicts drawn from slums, educational levels are low; when sampling from physician addicts they are obviously high. Education appears to be an associated variable incidental to use.

Information about opiate effects is related to heroin use. Chein *et al.,* found that only 17 percent of their heroin users had learned anything about heroin prior to taking it which might deter them; 79 percent of a control group of delinquent nonusers had learned about heroin dangers to health and life before they reached the critical age (for onset of heroin use in New York City) of 16. Stevenson's Vancouver study (1956) also bears on the matter of information; his addicts had friendly close associations with users prior to drug initiation; delinquent nonaddict controls did not have such associations and presumably learned less about use and less opportunity for it. The delinquent nonaddicts also had more negative information about opiates during their critical exposure period—they had seen overdoses or had watched a "cold turkey" withdrawal. The importance of information is compatible with other studies on other drugs. For example, LSD users (Blum and Associates, 1964) were informed about benefits; controls not taking it had more information about dangers or nonpleasurable effects. A cautionary and tangential point: One who might desire to immunize a child against heroin use by educational efforts must not equate information-giving with information acceptance. He must also be aware that information given in a frightening or noncredible manner is likely to be rejected.

Family Background. Robertson and Walton, reviewing the literature, find most investigators claiming poor family backgrounds for addicts; a poor background may include almost any quality deplored by the observer. Most studies have not used control groups. The observations on physicians earlier cited in this section are a case in point. Earlier studies cited by Meyer often report high rates of disorder in family members; criminality, neurosis, addiction, and the like. Sometimes interpreted as evidence of hereditary "taint," none of the early work on addicts enabled one to distinguish between the common pool of maladjustment in these families as a socioeconomic resultant, nor the "transmission" of maladjustment to the child through experience of being reared in a disordered family. Stevenson's study of delinquent addicts and delinquent non-addicts in Vancouver concluded that the addicts no more than the delinquent non-addicts came from marginal homes (as both groups did); and that addicts did not differ remarkably from criminal nonaddicts. Chein *et al.* (1964), on the other hand present findings showing a difference in family backgrounds; users more than nonusers, whether delinquent addicts were compared with delinquent non-addicts or with non-delinquent, non-addict controls, came from less cohesive families. Addicts were reared in families which provided poorer environments for personality development. The personality that could be expected to emerge from these families was one with poor adjustment abilities, an inadequate conscience, poorly developed life goals, inadequate masculine roles, and distrust of major social institutions.

Personality Traits. There are many descriptions of the personality of addicts, most of them suggesting that addicts lack initiative and self-reliance and are passive, inadequate and immature. See Meyer (1952) for an early review. Few control studies exist; one by Gerard and Kornetsky (1955) is an exception, as are those of Chein et al., and of Stevenson. Robertson and Walton (1960), reviewing the literature, conclude that the best demonstrated trait is that of a kind of sociability which makes group membership important and which makes the youth susceptible to the influence of those of his peers already using opiates. The Stevenson work supports this; they do stress the importance of falling into a pattern of associations in which use is accepted and taught, where earlier alcohol use had existed, and where traits of pleasure-seeking were combined, upon exposure to opiates, with reduction of stress and anxiety. Chein *et al.*, emphasize the aimlessness of the "cats" versus the "squares," their passivity and uncritical tolerance in accepting peers as opposed to the selectivity of nonusers. Their use of opiates was an extension of long-lasting and severe personality disorder and the addiction itself was functional in the sense it served a purpose for them, representing an "adjustment," a relief of pain, and perhaps a less arduous—so it seems at the time—road of life during periods of adolescent developmental stress. Gerard and Kornetsky, in an early study (1955), also found differences between addicts and opiate-exposed controls. Addicts had much more severe personality malfunctioning; none were "normal" adolescents. Half of the non-addicts were "normal." Although, concluding that opiate use did not develop into addiction without the presence of psychiatric disorder, the authors also concluded that personality disorder plus exposure to opiates does not necessarily lead to addiction. The particular problems of the adolescent-turned-addict, in the deprived urban sample under study, included constricted emotional responsivity, regression or withdrawal under stress, lack of close relation with others, underutilization of abilities, and oversensitivity to rejection. General unhappiness, difficulty in sexual identification, and poor interpersonal techniques are also confirmed. The psychopathology of controls may be similar; the authors speculated that the differences were then environmental; that the controls had not been hit by stressful situations requiring them to find a new style of life or a new set of gratifications. Controls (nonusers) with personality pathology appear to be potential addicts, since they did not reject opiate use as a possible activity; on the other hand they did emphasize goals and activities with people as a better way to achieve satisfaction. Controls who were normal on the other hand rejected drug use per se; this finding is consistent with the later work of Chein, with Gerard, showing that "squares" are not interested in drug experimentation. (It also suggests that information about adverse drug effects may be selectively learned and retained; it would be no accident then that the poorer adjusted drug-prone adolescents knew of fewer dangers associated with opiate use.)

In addition to the descriptions of personality defects, studies have been done of addict abilities, as for example, intelligence. Stevenson finds them to have the same intelligence levels of background as matched controls but to be operating at lower levels. Other studies, reviewed by Robertson (1960), show intelligence to be unrelated to addiction-proneness, except as a correlate of other population characteristics. There is no evidence of permanent decline in intellectual abilities as a result of opiate use; however, the studies done to date are not as complete as one would wish.

Personality Studies: A Caution. It is hard work to understand nature; it is hard work indeed to understand human nature. All studies of personality suffer from the inherent difficulties which face man trying to find the truth about his own kind. Personality research on drug-dependent persons is no better and no worse than that directed to other persons; the research reflects the state of scientific (and philosophical) development at any given point in time. The work done on dependency has been performed by dedicated and competent scientists; that their methods and findings be evaluated with caution is a good rule for anyone reading what another has done by way of seeking truth. That rule applies to work in all scientific areas, and, within the field of drug studies, for all levels and disciplines.

Personality studies on addicts have revealed a variety of characteristics, some on the surface and some "dynamic" or involved with the unconscious. Findings have varied depending upon the population studied, the interests of the scientist, and his methods. Most studies have not used control groups (where users are compared with nonusers of similar age, sex, class, etc.) and in studies which have used controls it can be difficult to distinguish findings from interpretations. A general problem exists in that the expectation of many clinicians is that drug-dependent persons are psychiatrically disordered so that when observations are made the expected traits are found. Few studies have employed the caution of blind interviews or tests in which the clinician is unaware of the drug status of the person. The Gerard and Kornetsky work is an happy exception. All work to date is retrospective, which means that the addicts studied have been identified as such by other agencies; their drug use and their experiences as socially stigmatized persons no doubt have altered their behavior. In consequence it may be that the disorders described are the result of drug use and social stigmatization rather than characteristics present before drug use started. This "masking" phenomenon in which apparent personality uniformity is the consequence of a long period of drug abuse is a pervasive difficulty in the study of drug dependent persons. What is needed of course are longitudinal studies in which populations at risk of opiate use are identified as children before actual use of opiates begins so that the preuse characteristics can be described without being confounded by after-the-fact elements. A tendency to overgeneralize may also occur. Because so many addicts are drawn from economically and socially deprived groups in which the production of defective personalities is high, one must find the preponderance of studies showing disorders in opiate users. The identified opiate users are "losers" in the sense they have not been able to manage their use discretely; one does not know the characteristics of the discrete opiate users not identified as addicts. Present generalizations describing the social and psychological inadequacies of addicts may be applicable only to the identified "losers," not to other kinds of users. Implicit here is that there are a variety of categories of opiate use, as we discussed earlier, and that samples of "addicts" do not represent a number of types of users which may exist within the population at large.

PERSONALITY STUDIES: SUMMARY

The President's Advisory Commission on Narcotics and Drug Abuse, in issuing its reports (1963), summarized the bulk of the impressions and findings on user characteristics, concluding that most were from deprived social groups and that most suffered personality maladjustment. The report correctly noted that individual motives and circumstances differed, but that most of those presently identified by public agencies lack vocational skills, economic opportunities or personality strength. Oriented toward the short-term drug experience rather than the long-term life road, the users' pattern of conduct before and after drug use is delinquent.

One should not, from such an overview, conclude that all slum-reared persons are either psychiatrically disordered, delinquent, or drug prone. Even from dreadful environments many fine strong citizens emerge; and among those who develop with lesser strengths the majority do not become dependent on opiates. We do not know all of the events which lead one person to addiction, another to experimentation only, and another to opiate rejection. One can say that among persons currently identified and studied as opiate dependent in the United States today that the probability of their having personality disorder is high, that their personality defects seem linked to their becoming dependent on drugs—and to their later inabilities to become abstinent—and that personality plays a causal role in association with other important factors. Personality disorder, no more than any other single factor could, does not "cause" addiction. For most identified addicts it is part of the constellation of misery which pervades the socioeconomic deprivation in the big cities.

INITIATION INTO OPIATE USE

Studies are in agreement that initiation into opiate use occurs as part of other social experiences, including those of medical care or living in a slum area. Initiation is a learned behavior which takes place either with one's peers or aided by older associates, or it may be—as in medical personnel self-initiation—use of methods already part of a working repertoire. The Chien *et al.* work indicates that the readiness to use drugs is part of the much larger fabric of personality, choice of associates, family background, and accident of residence. Stevenson's work also suggests the role of accident and social exposure. Unlike the New York City juveniles exposed to peer users, his Vancouver subjects were often unskilled workers attracted to the city who, laid off, engaged in petty criminality. In that they came in contact with criminal associates using opiates who initiated them. Eventually arrested and sent to prison they returned to civilian life less equipped for work, predisposed to a habit, and caught in a cycle of criminal associates and habit-supporting criminality of the same sort that led them into trouble in the first place. There is no evidence from any study of initiation as a consequence of aggressive peddling to innocents who are "hooked" against their will or knowledge. Opiate initiates can seek out the drug from using friends as part of curiosity or kick-seeking, or to demonstrate their being part of the group. Others may be more passive and fall into use as their peers engage in it. Whether seekers or passive accepters, the popular image of the fiendish peddler seducing the innocent child is wholly false. The Chein *et al.* work also indicates that it is false to assume that membership in slum area "gangs" is also conducive to opiate use; if anything, they conclude, street gangs discourage use and provide other satisfactions which can help prevent an inadequate adolescent from beginning an addiction pattern. The Chein work also calls attention to the fact that heroin, like most other mind-altering drugs, is not only a social drug in the sense that one is initiated to it by and with others, but that use may continue to be a social rather than a private event. For example, in New York street gangs whose members did use heroin, less than half (43 percent) of the youngsters were daily users showing addiction. The majority continued to be social users taking it casually, as for example on weekends. A point to be made here is that only for some persons, presumably those with major personality defects and no constraining personal relations, does the social use of initiation become altered into an addictive pattern where use occurs because of private cravings. Our interest then must be directed, not only at circumstances in which heroin initiation occurs, but at conditions which convert social use to private use (or medical use to dependent use).

OTHER DRUG USE

It is popularly held that *marihuana* is a "stepping stone" to heroin, one of such an order that some arguments against marihuana imply marihuana as a causal factor, as though that drug itself predisposes a person to progress to heavy drug use. Other arguments place marihuana in the context of the delinquent subculture, suggesting that a variety of illicit activities are available to adolescents, one of which is marihuana, and that as a mild substance its use may come first and, if satisfying, may help channel the drug-prone individual's interests toward further drug experimentation. In the early period of their work Chein *et al.* (1964) found that the majority (87 percent) of New York slum heroin users had first tried marihuana; however in their study of street gangs they found a different pattern where marihuana smoking had not preceded heroin use; they do not give a figure to document that statement. They do observe that marihuana was more commonly used than heroin and that 15 percent of their controls had smoked marihuana. The section on marihuana in this report describes how other populations (city dwellers in California, professionals using LSD, and professional controls not using LSD, etc.) also had 10 to 15 percent marihuana experience, and that such experience was not associated for most persons with any later experimentation with heroin.

On the other hand it is likely that in the population of heroin users presently identified, marihuana experimentation is a common part of a life pattern which later includes heroin. California BCS data for 1965 (Drug Arrests in California, Advance, 1965) shows that (*a*) most marihuana arrests were of young persons not having prior drug arrests, (*b*) most arrested for opiate use were older persons with earlier drug arrest histories, including marihuana and dangerous drug arrests, and (*c*) most dangerous drug arrests were of persons younger than either the marihuana or opiate arrests group. This data is suggestive only, but is compatible with the notion of a sequence in drug use from dangerous drugs to marihuana to opiates in at least one subculture of drug users. California trends also show that opiate arrests (primarily heroin) are becoming fewer but that there is an expansion in dangerous drugs and marihuana (only 2 percent of California 1965 drug arrests were for opiates and cocaine). That trend is compatible with the notion that the drug using subculture identified by California arrest statistics is changing and that the earlier possible marihuana to heroin progression among past identified heroin users is shifting. It is imperative that all such inferences from arrest data contain the caution that drug-use patterns are fluid and that people and circumstances (including drug availability), not the pharmaceutical properties of drugs alone, determine priorities for drug experimentation and patterns of use among drug-interested persons.

With reference to the belief that marihuana causes heroin use in the sense that it predestines its user to go on to bigger things, there are two critical tests: one asks what proportion of marihuana users do not go on to heroin; the other test asks if marihuana use is an inevitable and necessary precondition of heroin use, that is, can it be shown (*a*) that all heroin users first took marihuana, (*b*) that such marihuana use is the only factor common to heroin users, and (*c*) that the presence of this common factor can be shown experimentally to be a determinant of heroin use. The results of such tests are, of course, negative. Most persons who experiment with marihuana do not try heroin, some heroin users (we have not been able to find any consistent figure of heroin users with and without marihuana experience; certainly it is clear from Asian cultures that opiate use can occur without any exposure to marihuana) even in slum cultures (see Chein, Stevenson, etc.) have not first tried marihuana, and among heroin users first trying marihuana a number of other common factors are also likely to be present. Among these may be experimentation with other illicit drugs reflecting a general pattern of drug interest and availability.

TOBACCO AND ALCOHOL

The Chein *et al.* New York work found alcoholism more frequent in delinquent-producing families as opposed to nondelinquent controls, but alcoholism frequency in families was no greater for addict than nonaddict delinquents. Other observations on New York slum delinquents suggest that the frequent illicit use (as minors) of both tobacco and alcohol occurs after age 11 or 12 and, in terms of the critical heroin onset age, the age of 16 is set by Chein *et al.* Stevenson's Vancouver study reports that addicts used alcohol earlier and more intensively than nonaddicts, suggesting the prodromal role for alcohol in the development of some opiate addictions (Stevenson's addicts were also more promiscous sexually—and half of his women were prostitutes first—that supporting an alternative interpretation of more flagrant asocial experimentation with sensory experience). Robertson and Walton, reviewing published studies, find considerable contradiction in the literature regarding the role of alcohol either prior to opiate use or as part of a pattern of concurrent use. Attention to the role of alcohol or tobacco—or other drugs—in the life of the opiate user does emphasize the importance of patterns of drug use by individuals and reminds us not only that dependency can occur for many mind-altering substances, but that there can be cross tolerance, interdependency, and multihabituation.

Genetic Factors. In the 19th century it was fashionable in Europe to speak of familiar or inherited addiction, especially with reference to alcohol. In the United States with its emphasis on the importance of environment, class mobility, education and opportunity, the relative disinterest in genetics among social scientists may have been as much for cultural as for scientific reasons. In recent years, however, the very exciting developments in genetics itself, and in the intimately related field of molecular biology, has led to renewed attention to behavioral genetics. Nevertheless in the field of human addiction very little can be said. Unsatisfactory family backgrounds, as we have seen, are often described; but these are conceived in a sociopsychological rather than a genetic framework. Work by Fischer and Griffin (1961, 1964) on humans suggests genetic features associated with cigarette smoking and work on animals by Nichols (1950) and by

Rodgers and McClearn (1962) shows that liability to morphine addiction can be bred in strains of rats, thus demonstrating that in animals at least genetic components play a role in the development of opiate dependency. Whether work with humans will verify gene-linked dependency to opiates remains to be seen.

RISKS ASSOCIATED WITH OPIATE USE

At the outset it must be made clear that the risks associated with opiate use should be considered not only in terms of the physiological effects of the drug but in terms of how persons respond to those physiological changes and how society responds to persons who are identified as using opiates. Thus "risk" is a compound of drug effects and users and social responses.

The physiological effects of opiates vary, as with all mind-altering drugs, depending upon the particular chemical structure of the drug, and upon dosage and route of administration, time of administration and circumstance, the personality and expectations of the person himself, and other variables at levels ranging from the biochemical to the cultural. Drug effects are, as we have mentioned in other sections of this report, complex in determination, especially within that range of dosage which is usually employed, that is, in intermediate dosage ranges where the person remains aware and exercises some choice (or can show some variability) in his behavior. As dosage increases the predicability of effects becomes greater, but the predictability is physiological more than in terms of social behavior; that is, with high doses of almost any powerful mind-altering drug extreme physical responses such as psychosis, sleep, coma, shock, confusion associated with brain syndrome, or death will occur. Morphine, for example, in conventional doses produces mental clouding, physical inactivity, nausea, itching, sweating, etc. (Martin, Beecher). Normal subjects consider these feelings unpleasant; addicts may seek them out. Intensified activity or sleep may occur; the intravenous administration of opiates may also produce abdominal sensations reportedly akin to orgasm. Some persons will feel "high," others "sick"; some will feel less anxious, others more anxious. These subjective responses will vary with person, setting, knowledge, etc.

The physiological risks of opiates, other than long-term risks associated with the development of dependency through tolerance, euphoria, and the attempt to stave off withdrawal symptoms, include death from overdose. One of the special features of the opiates (and certain other mind-altering drugs such as barbiturates and some tranquilizers) is that death may also be produced by not giving the drug. That is the classical withdrawal or abstinence syndrome associated with opiate deprivation in an organism which has been receiving heavy doses of the opiate. Withdrawal produces death only rarely in humans, more often it produces "autonomic storm," a state which includes watery eyes, running nose, sleepiness, later restlessness, sweating, muscle pains, and still later, nausea and diarrhea. Appetite loss, elevation in temperature, increased respiration and blood pressure all occur within a 48-hour period. Distress may continue for weeks and it may be months before physiological stability is achieved—this is true for animals as well as humans (Martin). Behavior while under normal doses of opiates must be distinguished from "craving" behavior involved in seeking the drug to avoid withdrawal symptoms. There is clinical agreement that during "maintenance" doses of opiates reduction of physical or mental task performance need not occur. Experimental studies, reviewed by Richardson and Walton, confirm this although experiments can be designed in which poorer performance under opiates is achieved; these seem to depend upon conditions of incentive, instructions, etc. Beecher's work affirms mental clouding as a subjective state. Earlier studies do report decrement in memory abilities; there seems to be no recent research on this. There is general agreement that little association between opiate use and psychosis occurs. These studies on performance have bearing on the problem of risks, as for example, risks of accidents.

OPIATE USE AND ACCIDENTS

We have found no studies on the relationship between opiate use and vehicular or industrial accidents. Nor have we found information on the prevalence of driving while under the influence of opiates. A case history study by Kolb of (Lexington) addicts attested to their industrial efficiency. About half performed normally; there is no mention of industrial accidents in the group. Kolb notes that no addict classified as emotionally normal showed a poor industrial record. One may infer, without being sure, that industrial accidents would have been reported in these records had they occurred. With reference to the general performance of addicts a number of observers (Wikler and Rasor, Eddy) call attention to the possibility of quite normal functioning for addicts supplied with maintenance doses. Only after opiates are withdrawn does performance deteriorate. Consequently, although no studies on driving skills have been done during the on-drug and off-drug phases, one can speculate that some addicts will show increased accident risk when not under the influence of the drug while performing well under opiate influence. Such a speculation requires laboratory testing under adequate simulated driving conditions. The probability has been referred to elsewhere in this report that persons clinically improved by one or another drug will drive better when "drugged" than when without their medication.

OPIATE USE AND SUICIDE

No satisfactory data exists on the relationship between suicide and opiate use. Followup studies on addicts (Ball, Bates, and O'Donnell, 1966) show a high death rate among addicts released from Lexington; higher than ordinary death rates are also found among Formosan opium users (Tu, cited in Kolb). Whether or not those higher death rates reflect suicides as well as the health risks which ordinarily challenge the socioeconomically deprived populations who become identified (American) addicts cannot be said. For example, other diseases such as tuberculosis and schizophrenia are also reportedly concentrated in low-income, poor health care groups. In a follow up study of 47 physician addicts Pescor (1942) found two suicides. In another study Pescor (1940) described 1 percent of an addict population as suicidal as well as several who had disappeared. Quinn's study (1961) of physician addicts reported a rate of 8 percent. O'Donnell has compared the suicide rates of Kentucky resident patients released from Lexington with Kentucky residents as a whole. During a 24-year period, from a sample of 266 treated during that time, 130 had died. Of these 7 (2.7 percent, all males) were known suicides or a (converted) rate of 538 per 10,000. The Kentucky male population suicide rate (known, it is to be presumed many suicides are undetected) was 170 per 10,000. The Chein *et al.* work holds that suicide occurs in addicts during the readdiction cycle at the point when the user has become readdicted and is depressed about it and about his chances for social adjustment. They state that suicide is a serious hazard for addicts but they do not document the claim. Whether the opiate overdose deaths which occur, rare among drug-tolerant chronic users according to Kolb, but more common in abstinent users returning anew to use, include suicides has not been ascertained. If one follows Shneidman's (1964) thesis that many kinds of "cessation" behavior are suicidal, then opiate use itself must be suspected of kinship to other forms of suicidal behavior. At the present time the evidence is slim, but the various threads suggest that (*a*) given the kind of persons who become addicts, (*b*) given the possible equivalence for some between opiate use and cessation of conscious awareness, (*c*) given the circumstances of society's response to their addiction and the likelihood of their own distress over their social position, and (*d*) on the basis of suggestions from research to date, then suicide is a risk associated with addiction at a rate greater than for the population at large. One is speaking here of identified illicit addicts, not of the users of opiates who are not classified as offenders.

OPIATE USE AND OTHER CRIME

Our figures on medical opiate use demonstrate that most opiate use is not criminal, or at least is not adjudicated as such regardless of the circumstances of use. For the purposes of discussion here we shall eliminate those crimes which are defined by the act of acquiring, producing, selling, transporting, or possessing opiates. We shall limit ourselves to the question of crimes associated with opiate use. At the outset, by way of an initial summary and orientation, one may state that remarkable variation in findings occurs and that it is clear there is no uniform or inevitable association of opiate use with crime. Crime rates depend upon the nature of the addict sample being observed.

O'Donnell has done a recent (1966) and careful review of narcotic addiction and crime. Reviewing the literature, he finds that ecological studies are in agreement that city areas of high opiate use are also areas with high rates of crime and delinquency. Other work shows that the delinquent orientation associated with opiate exposure and later dependency is, in individuals, also associated with other criminal activities. Whether identified addiction precedes or follows other recorded criminality varies by population group. A 1937 Chicago study (Dai) showed 81 percent without criminal records prior to drug arrest; since his sample were offenders, all had postdrug criminality—most limited to narcotics offenses per se. Pescor found among Lexington addicts in 1936–37 that 75 percent had no prior delinquencies whereas after addiction 82 percent had such records—again an unstated number being narcotic offenses per se. O'Donnell cautions that Pescor's was also a sample selected by virtue of their being later offenders. Vaillant and Brill, cited by O'Donnell, found that 57 percent of a New York sample treated at Lexington had antisocial records prior to addiction with 46 percent serving time; afterwards 92 percent served time (again some unstated number being narcotics offenses per se). Chein and Rosenfeld and Chein *et al.* have described changing delinquency rates. They contend that high-drug areas in New York City showed increasing property crimes; delinquent but low-drug areas showed increasing "disturbance" crimes. (We cannot affirm that latter conclusion on the basis of the tabular data they offer.) Finestone (1957) also reports increasing property crimes and decreasing crimes of violence after the onset of addiction. O'Donnell's own study of 266 Kentucky residents after release from Lexington shows that 63 percent of the men had no arrests prior to addiction (presumably arrest for opiate use) whereas afterwards 62 percent had such arrests. Prior to addiction 93 percent of the women had no arrests, afterwards 26 percent were arrested. O'Donnell's data establishes a relationship between age of drug offense and probability of prior nondrug criminality. The younger a person at the time of the addiction arrest, the more likely his prior history of non-drug criminality. Similarly the younger the age of addiction, the greater the chance for arrests after release. A breakdown of types of crimes before and after identified addiction shows for males 30 percent non-narcotic offenses before (6 percent involving violence or the threat thereof) and afterwards 47 percent (5 percent involving violence). For females, 2 percent were non-drug arrests before, and afterwards 15 percent were nondrug arrests.

O'Donnell divides his sample into groups depending on the source of their narcotics and finds that almost no addicts receiving their drugs from one doctor had post-release crimes, that addicts receiving drugs from several doctors had post-release arrests in only 23 percent of the cases, that addicts who were themselves physicians experienced only 25 percent rearrest, that addicts who had both medical and illicit street sources had 38 percent with no rearrests, and that addicts whose drugs were an illicit street supply had 72 percent rearrests. There are several explanations of these findings which are acceptable. One is that persons procuring drugs from doctors (even if the user may employ fraud and deceit in so doing) are not visible to enforcement officers because of the private and privileged nature of the doctor-patient relationship. It would also be the case that drugs so procured are low cost and do not impose an economic strain on the user of the sort which might lead him to steal to get drug money. At the other extreme, street addicts are subject to considerable police surveillance, must expose themselves to arrest risk in procuring drugs from others, and must pay higher prices for drugs so that, in association with the delinquent user's usual low earning potential and job instability, there may well be an added or prime motive for theft. On the other hand, the likelihood is considerable that the subculture of the users getting drug supplies from doctors is quite different from the street heroin users. The former are likely to be higher status and socially better adjusted; the latter are likely to have a more delinquent outlook where heroin use and other criminality are part and parcel of the metropolitan slum package. It would be helpful if some other study would view a control group of matched Kentucky residents longitudinally to establish their career of crime and drug progression. Helpful as O'Donnell's study is, and assuming the statistical significance of the prearrest to post-arrest shift (which we have not calculated—out of 192 males 32 had property arrests after but not before identified addiction), the uncontrolled factors include (*a*) actual drug use, as opposed to identified addiction, (*b*) the effect of the Lexington experience and release, and (*c*) the proportion of post-Lexington arrests attributable to prior identification as an addict. What this means is that the findings could equally be attributable not to addiction, whatever that may mean, but to becoming a Lexington patient and being released.

It is also very important to bear in mind that a young pre-addict has less exposure to arrest than an older released addict. Short and Nye (1957) and others have shown that the chances for being caught increase with both the severity and frequency of crimes. Assuming an equal distribution of criminality over time, a 17-year-old for 3 years prior to addiction has less chance of being caught than that same fellow released from Lexington and continuing the same offense pattern for another 20 years. It is hard to imagine that sheer exposure does not increase post-release criminality rates. Criminality and age do, of course, interact to produce other changes affecting identification including professionalization of crime (with subsequent reduced arrest potential), maturation, shift in criminal activities from visible to less visible arenas (auto theft to gambling for example), and, on the increased visibility side, to increased liability to arrest once known to the police.

O'Donnell interprets his age and crime-change findings as evidence that addicts are increasingly being drawn from younger delinquent samples. He finds this compatible with other studies and he correctly concludes that drug use per se does not cause crimes; he also implies wisely we believe, that both pre- and post-addiction criminality is related to the source of drugs of the person, that in turn very probably being related (our interpretation) to matters of socioeconomic background, personality, access to respectable channels, and the like.

Kolb analyzed the records of 181 Lexington cases and concluded that morphine and heroin suppress rather than excite crime; addict offenders in his sample had been delinquent prior to addiction. He observes that as part of their generalized instability criminals become addicts but that addicts do not become criminals because of the drug. Further, Kolb holds that crime rates would not be altered—except for narcotics crimes per se, theft, and prostitution—were all illicit drug use to be eliminated. Other studies include those of Vogel (Maurer and Vogel, 1954), who notes that reduction of sexual desire accompanying opiate use means that opiate users are most unlikely to be engaged in aggressive sexual crimes. Maurer and Vogel make observations suggesting that while petty crimes may be associated with addiction, professional crimes requiring either manual skill or complex interpersonal relations (safecracking, the rackets, etc.) are incompatible with addiction. In terms of the cost of opiate-associated crimes, these, like estimates of the value of illicit opiates themselves, are subject to considerable error. A figure offered at the first White House Conference on Narcotic and Drug Abuse (interim and final reports) attributes $500 million a year in property crimes to addicts in the New York area alone.

Among the variety of other reports dealing with narcotics and crime we cite the 1950 statistics of the Chicago Police Department (Finestone) showing higher rates of larceny and robbery for addicts over other offenders listed in departmental records; in contrast the addicts were lower in sex offenses, auto theft, assault, and weapons possession by a considerable factor. Morgan (1965) reports on a 1959 and 1963 investigation revealing that a majority of New York City addicts had criminal records prior to identification as opiate users; after identification those without prior offenses were, for the most part, limited to narcotic offenses per se. Morgan concludes that addiction is not a cause of crime but a product of delinquent lives. Examining the rapsheets of addicts admitted in 1965 to the California Rehabilitation Center, it is found that the majority of prior offenses were for other drug use; only 5 percent were without earlier recorded criminality. Bridges, in a careful examination of California statistics, shows that rearrest in once-identified addicts is a function of exposure, the longer after a man has been identified as an addict the more chance for his being rearrested; in California the rearrest chances increase by 10 percent each year; for the most part these are offenders with criminal records prior to identified opiate use. Bridges' finding supports the earlier warning that a rise in post-addiction criminality may occur in part because of a longer exposure period during which crime can be detected. After about age 40 a number of addicts cease to be reported either as addicts or as criminals. That finding is compatible with the "maturing out" thesis advanced by Winick; it is equally compatible with disappearance through death, departure, or other institutionalization. Further consideration of the shift in time of apparent addiction is beyond the scope of this report.

What is important to emphasize is that neither official statistics for narcotics offenses or for other criminality represent all offenses committed, and that one does not know whether persons who become identified as addicts also suffer an increased liability of identification after institutional release for either narcotics or other offenses, in contrast, let us say, to either a group of nonaddict parolees or probationers, or to a group of discrete delinquents whose crimes remain in the dark-number category not known to or reported by law enforcement. Until that is known the extent of increased postaddiction criminality remains open to question regardless of the logic of the thesis and the directness of police observations to the effect that addicts need to engage in crime to support their habits. One must keep in mind that "kicking the habit" is quite possible for most opiate users, i.e. those receiving medical opiates, and that the compelling nature of addiction, used as an explanation by addicts for other criminality, cannot be accepted as sufficient cause for their delinquency. It is equally possible that their addiction and their criminality, when these occur together which is not always the case, are simultaneous expressions of delinquent maladjustment—or the consequence of an unkind social environment (whatever the phraseology one wishes to use)—neither of which is readily abandoned by persons lacking personal resources, social opportunities, or commitment to "square" ideals. It is only necessary to remember the very low success rates in the rehabilitation of slum-origin delinquents to point up that criminality itself has a compelling nature if the definition of compulsion is the repetition of acts. Again, as the Gluecks have shown, a "maturing out" process occurs so that many youthful offenders are no longer reported as criminal after the age of 30. At the present time what we can do is to identify those persons whose environments and styles of life mark them as risks to themselves and to others, regardless of whether they are first identified as opiate users, thieves, or something else. The nature of the event which brings them to official attention may be significant in establishing the particular syndrome which is theirs, and this criminal pattern identification can be helpful to us in planning both prevention and control, if not treatment. It does not appear fruitful to concentrate so much on the nature of events, as for example opiate use per se, that we deem them the cause of the multiple problems which the individual both reflects and creates. Similarly we cannot assume that the mere control of the presenting event, as for example the suppression of opiate use, represents a solution either to the suffering of the individual user or a reduction of the threat he can present to the property of others.

OPIATES AND CRIME: SUMMARY

At the present time most known opiate addicts have been delinquent prior to their being identified as users and most continue to be arrested after release from hospitals and prisons. Changes in the association between delinquency and opiate use occur over time and differ among cultural subgroups. At present there is a tendency for individuals after release to experience an increase in arrests over preaddiction experience, these arrests primarily being for narcotics offenses and secondarily in connection with crimes against property. There is no evidence that opiates are a cause of crime in the sense they inevitably lead to criminality, but there is no doubt that among addicts with a delinquent life-style drug use is part and parcel of their other activities, crime included.

There appears to be no solid ground for extreme anxiety or outrage over the current dangers posed to the community by opiate use; claims for the inevitability of either dependency or dramatic increases in individual criminality in consequence of opiate use are much exaggerated. On the other hand there is no evidence that opiates are "good for you" except in the short-term reduction of anxiety in medically controlled settings. Consequently even though opiate use by anxious delinquents, or others seeking escape from one or another form of distress, can be considered self-medicating in the sense that their felt distress is temporarily reduced, their choice of "medications" creates further difficulties for them which are likely to be of a physiological as well as a social and legal nature. Insofar as their opiate use leads to effects which incapacitate them socially, or perpetuates membership in asocial or antisocial groups, that use also poses serious problems for the community at large. There can be no question that identified addicts are a group deserving of public attention. Their opiate use is a signal of their own distress and a warning of the existence of what can be a long-lasting asocial or antisocial trend.

GENERAL COMMENT

In this report we have not discussed the evidence dealing with the rehabilitation of identified opiate users. Depending upon the definition of "abstinence" employed including the length of the follow-up period, duration of abstinence or reduced use, the inclusion or exclusion of dependence on other drugs, or the continuation of other forms of delinquency or social maladjustment, the figures for rehabilitation success range from 90 percent success to 97 percent failure. Our pessimistic view is that for the kinds of persons currently identified and "treated," whether that be conventional imprisonment or medical or psychological care, the success rate for persons under age 40 is discouragingly low. Given the early age for delinquent addiction and the consistency of later misbehavior for these persons, there is no support for any optimistic assumption that they simply and willfully "choose" or "elect" their style of life, nor that given the right opportunity they will elect to become less troubled and less troublesome members of the community. We are, of course, speaking in terms of group probabilities and not for the remarkable individual cases which can be cited. The burden of cost on the community arising from crime, from social welfare efforts, from police efforts, and from the processing of the addict through the courts and to prisons or hospitals is undoubtedly great although we have found no actual estimate of the amounts of money involved. The burden to the addict is also severe and, since he feels it constantly, no doubt considerably more intense and salient than the drug-related costs and worries which affect and are shared by the law-abiding citizenry. The citizen burden is, however, just part of the larger and clearly pressing cost and danger which arises when a large sector of the metropolitan population is ill, anguished and criminal.

If we consider the tendency toward more youthful opiate involvement and if we link that to the generic tendency toward greater youthful use of illicit drugs (California for example, experienced a 33 percent increase in juvenile drug arrests in 1965 over 1964 although these were for marihuana and dangerous drugs, primarily amphetamines rather than opiates—see California Drug Arrests, Advance Reports 1966), if we consider rising crime rates which are associated etiologically with delinquent area drug use, and if we consider the failure of any known program to prevent delinquent addiction or to cure identified addicts, we may conclude that our troubles are expanding and our means for coping with them insufficient. It seems pointless to blame "the community" which both suffers from these effects and, socioeconomically, produces them without so intending, just as it is pointless to blame "law enforcement" for not preventing or controlling that criminality whose origins are patently beyond the control of the most dedicated and competent law enforcement personnel. It is equally futile to blame the offenders, those often inadequate and hopeless people who could hardly be considered to have chosen to be miserable, even if they reward themselves with fleeting pain reduction or glimpses of pleasure through drugs. What is indicated is a search for better methods for the control and rehabilitation of individual distress and criminality, including research, as so strongly called for in the Final Report of the President's Advisory Commission on Narcotic and Drug Abuse in 1963, and socioeconomic action of the sort envisioned in a variety of private and public efforts designed to eliminate poverty and ill health and to generate improved education, mental health, and vocational opportunity. These are, of course, very expensive and long-term efforts and we have no evidence, in spite of our national commitment to progress and a finer way of life for all, that they will succeed or even keep pace with the metropolitan deterioration which we are now experiencing.

Lest one be too discouraged by the magnitude of the task and the total lack of assurance of success in its accomplishment no matter how extensive our national effort (some philosophers have, after all, labeled the credo of Western man as the "myth of progress" and Dubos has described the "mirage" of health), it is well to return to the perspective on narcotic abuse provided by our earlier estimates on the extent of use compared to the incidence of addiction. No more than 1 out of 1,000 Americans becomes an identified opiate addict. For those not living in deprived and delinquent metropolitan areas the chances for becoming an addict are almost nil. Most Americans have used opiates without any residual ill effects. For most persons the opiates are not euphoria-producing substances and for most the risk of becoming dependent appears quite low. Even those who do become drug dependent appear to get along, in many cases, well enough to be considered reasonably normal citizens. The opiates themselves have not, under present systems of medical and legal control, presented extensive difficulties. At the same time millions of persons suffering from anxiety and pain during illness have experienced relief through opiate medication.

RECOMMENDATIONS

It is beyond the province of this report to make systematic recommendations or to become partisan in argument. We have sought to limit ourselves to the presentation of the facts about use, as best we could determine them, and to the correlates of opiate use. Nevertheless, if our assessment of the facts of use is reasonably accurate, then there are certain directions which would seem sensible ones to pursue. We shall set these forth in general terms, acknowledging that in an area so much colored by public apprehension, inconsistencies in scientific findings, and the fixed and intense positions taken by advocates of one or another "solution," it is unlikely that any set of recommendations—however much they appear reasonable and in keeping with reality to those proposing them—will achieve universal agreement in an audience with considerable diversity of opinion.

As one recommendation it would appear that if it is correct that chronically psychologically disabled persons, and secondarily those undergoing acute personal or situational distress (as for example physicians in mid-life or patients made pathologically anxious by illness), are the persons most vulnerable to opiate dependency, then these persons are the primary targets for preventive efforts. Since they themselves may not be able to anticipate their vulnerability, and certainly not to control it by any act of will, others in their environment must take responsibility. Others must be on the lookout for signs of impending or present drug dependency. Those "others" are the "gatekeepers" who are in a position to supply opiates or to observe when unhappy or delinquent or ill persons may be using opiates. One speaks here of physicians, nurses, druggists, but also of parents, siblings, husbands, and wives. One cannot be on the lookout for telltale signs of increasing drug use without being informed. Consequently, one important step would be increased education—in school and in public information campaigns—directed at these important "others" who can be made alert to the risk of opiate use among those with access to the drug. Education to risk is insufficient; the information must also include very specific directions on handling. That handling would reasonably appear to be in the hands of trained public health personnel to whom parents or physicians may direct their at-risk-of-becoming-dependent charges. One cannot expect one person who loves or cares for another to place their charge in a situation of jeopardy. That means that provisions must be made in all metropolitan areas not only for the non-punitive (i.e., without arrest and incarceration) referral and treatment of drug-dependent persons, but for their treatment being inviolate as well. That is to say, patient records must be forbidden release to other agencies or persons unless explicit patient permission is granted. That is, of course, conventional medical practice but it must be emphasized so that no parent will feel he is delivering his child into the hands of the law.

Beyond the education to care, responsibility, and referral to treatment directed to family members and medical and allied professionals, a strong effort is advisable toward the education of a second line of case finders—citizens in key positions. These are persons in vantage points who also have a chance to be on the lookout for conditions predisposing to addiction (i.e., asocial or antisocial outlook, personal inadequacy, and drug availabilty) among those with whom they come in contact. This second-line group includes school teachers, employers and work supervisors, recreation and block workers, juvenile bureau police, social caseworkers, and others. Guidance for them might be modeled on presently emerging community psychiatry consultation and public health education programs. Education for these groups might well be developed in their professional schools, in their in-service training, and at summer institutes and special seminars. For these vantage-point people, education must include explicit direction on the "to-whom" and "how" referral of persons suspected of becoming drug dependent.

It is beyond the scope of this report to consider particular programs for drug control or individual rehabilitation within the agencies given responsibility for receiving referred cases. Nevertheless, given the suggestion that there be an "early warning" program which encourages parents, teachers, physicians, and others to bring vulnerable and drug-dependent persons to public health agencies, it follows that these agencies must exist, must have adequate staff and facilities, and must be intimately involved in an integrated community effort to combat any ill effects of drug dependency. Within such agencies emphasis must be on research, since present therapeutic efficacy is not demonstrably great. One must comment here that even without cures, many systems advance considerably by being humane and by preventing further degradation to and stress for drug-dependent persons. It is also important for treatment agencies to recognize, as is increasingly being recognized among medical care authorities, that the style of services must fit the habits, language, and cultural expectations of those receiving service. That means that there needs to be special training for the treatment personnel in how to listen to and how to be understood by the poor, the uninformed, the angry, the shy, and the suspicious. It will also mean—in many instances—that the professionals must come to the patients rather than vice versa. To establish one's treatment centers in the heart of delinquency areas is one such step.

Individual treatment, while essential and important, is a less and less effective procedure—when one is dealing with whole populations at risk of drug dependency—than is prevention. Preventive efforts in turn must be tailored to the kinds of groups about which one is concerned. Prevention of dependency among medical personnel obviously requires a different program than the prevention of addiction (i.e., arrest for use) among slum delinquents. For those in delinquent slum areas, who now constitute the population most likely to engage in other street crime as well as narcotics use, prevention must obviously be a social and economic effort. The painful facts of life about the dire effects of poverty, ignorance, discrimination, unemployment, family disruption, and all of the other miseries of the blighted metropolis are known to all thoughtful citizens. The relationship of these milieu factors to the particular symptoms of ugliness and misery such as crime and illness and drug addiction are also widely known. It is likely that those task forces of this Commission concerned with any form of slum area crime will add their voices—and their efforts—to those many other agencies and citizens who seek the elimination of poverty, inequality, and despair.

In addition to efforts to educate and involve persons in vantage positions for the observation and referral of drug-vulnerable individuals, in addition to augmented treatment and research efforts, and in addition to the massive socio-economic reform of metropolitan blight, certain practical and immediate backup systems to monitor opiate importation, processing, and distribution are necessary. Present law enforcement, pharmaceutical industry, and medical professional controls represent such efforts. The endeavors of law enforcement in particular are an increasing subject for public debate and of court decisions. Given the nature of opiates use as a vice in which only consenting parties are involved, the demand upon the police to identify and provide sufficient evidence for and conviction of drug users has led to a number of functional or adaptive police responses of a controversial nature, these including the use of informants, promise of immunity, near-entrapment, drug purchases by undercover agents, invasions of privacy (wire tapping, etc.) and constitutional violations involved in search and seizure. One cannot blame the police for evolving techniques to combat offenses that the law and public sentiment require they combat. One does wonder if the cost of this effort—not only in terms of dollars and police time but in terms of the bad police-judiciary relations resulting from cases brought to the higher courts and in terms of the rate of recidivism among apprehended addicts—may not exceed the community value received. The solution sometimes proposed is that the police disregard the user and concentrate on the pusher. At the street level these appear to be one and the same person. At the higher level of importation and wholesale distribution, police efforts have not met with noticeable success in spite of the most dedicated endeavors. Quite likely the obstacles to preventing opiate distribution are the same as those facing any vice-controlled operation where criminals are organized and business-like, not being aberrant in their ordinary conduct, and being tempted by high profits and an ever-present public market which brings new operators into the traffic as quickly as old ones may be arrested. These difficulties are well-known to law enforcement and public officials. All considered, the question is whether the fact of illicit opiate use itself merits the street-level effort the police must expend. Viewed from almost any standpoint, opiate dependency is agreed to be but a symptom of psychological disorder (even if its origins are social or even genetic). To work so hard at symptom suppression through means which cannot be shown to correct the offender is dubious. To attend so fixedly to behavior which is, in some ways, only an incidental criminological concern raises serious doubts about the economy of our efforts. Our recommendation here is limited; we ask that serious attention be given to changing the focus of police control to exclude from criminal penalty the acquisition or possession of opiates without intent to sell. Emphasis on higher echelon importation and distribution for illicit purposes would remain a police task—and a very difficult one for which additional technical and statutory support for law enforcement would no doubt be required.

One must recognize that any actual elimination of opiate addiction from being a criminal offense would require simultaneous controls on the means for legitimate supply. One would not wish to encourage the nonmedical use of opiates, yet one cannot anticipate what changes in patterns of use would emerge; quite likely some users would maintain themselves in a state of stupor, others would exploit the system (as is now occurring in Britain, see Chapple) to procure drugs which in turn they would employ in recruiting new users. Some would adjust to maintenance doses; others over time would drop the habit. What the ultimate "mix" would be, no one can be sure. Experimental programs might give guidelines, careful continuing evaluation of developments under more permissive laws would be required, and a state of alert legislative flexibility would be much in order so that statutory revisions could be enacted should it be shown that further laws, either limiting or enabling, were needed.

Unless one is willing to make dramatic and controversial changes in policy and law, ones admittedly leading to unknown changes in drug behavior, one cannot reasonably expect much change either in present police practices or in addict careers. Superficial changes in agency jurisdiction, numbers of enforcement or treatment personnel, or availability of funds for present operations would signify a less than genuine wish for basic changes. Whether basic changes are desired is a decision which ultimately rests with the citizens of this country and with their elected representatives. Expert groups may express their professional opinions and render their best advice, but the actual handling of narcotic offenses is a matter of community morality, tolerance, and opinion. If the community does not wish to make dramatic changes in prevention or treatment in present criminal law, then it cannot expect dramatic improvements either. It must be allowed that dramatic changes also carry the risk of dramatic failure, witness prohibition as an example.

Realistically one does not ordinarily expect sudden shifts in community beliefs and morality nor in the criminal law pertaining to vice offenses. Nor can one expect remarkable shifts either in the patterns of urban life which tie together slum delinquency and opiate use or in individual idiosyncrasies which make some nondelinquent persons vulnerable to opiate dependency. The "either-or" formulation set forth in the earlier paragraph is not a choice which most lawmakers or citizens would find agreeable. The predictable course is for slow social change accompanied by debate, the testing of possible solutions in a piecemeal fashion, and the construction of compromises between various sectors of the political, professional, police, and lay publics. Given that likelihood, then the general recommendation which is in keeping with long-range goals is for a greatly expanded debate, one given considerable continuing publicity, among the advocates of the several extreme positions regarding opiate use (e.g., Federal Bureau of Narcotics, methadone maintenance clinics, the "British system," etc.). The hope is that such debate will arouse public interest and will, over time, lead to that exchange of information and growth of understanding which is required to build a legislative and policy consensus.

In the meantime a number of step-by-step changes in policy and practice will be proposed by interested parties. We suggest that there are a set of standards which can be used to judge each. Of each proposal one can ask:

☐ Is it humane in that it does not inflict suffering on a fellow human being?
☐ Is it economical in that it can be shown to cost less than equal effect alternatives?
☐ Is it efficient in that it can be shown to work?
☐ Is it necessary in that it changes anything of real importance?
☐ Is it in the public interest, as opposed to being a step which, without necessary benefits either to addicts or community well-being, merely serves to advance the power or primacy of one or another interest group?
☐ Is it safe to persons in that it can be demonstrated not to increase the risks of drug dependency in persons not now drug-dependent?
☐ Is it safe to communities in that it can be shown not to increase the risk of crimes against property or persons?
☐ Is it sane in that it is not based on false premises about either the extent of opiate use or the probable effects of that use?

NARCOTICS SUPPLEMENT: COCAINE

Our definition of narcotics restricted the previous section to the opiates and their synthetic analogs. One drug usually included in statutory definitions of narcotics is cocaine (or other coca leaf preparations). Pharmacologically, cocaine is not considered addicting in the sense that physiological withdrawal symptoms are not present; tolerance and dependency have been described. Very early studies by Lewin reported occasional animal dependency and, in man, physiological excitation following use. Although coca leaves are generally chewed, prepared coca or cocaine may be sniffed, injected, chewed, smoked, or rubbed into the mucosa. In man, cocaine reactions vary; central nervous system irritability is observed and, in large doses, convulsions and death occur. When used chronically through sniffing, nasal ulcerations can be induced. In cocaine-dependent persons, clinicians (Lewin, Kolb) report euphoria, exhilaration, appetite loss, digestive disorders, nervousness, sleeplessness, hallucinations, and paranoid-type psychoses. The medical use of cocaine is as a local anesthetic; a use compatible with the results sought by coca-leaf-chewing Indians in the high Andes, large numbers of whom use it daily. There is no data on the present extent of illicit cocaine use in the United States. Kolb has described both chronic and occasional users in typical addict populations. It is employed by heroin users to potentiate altered feelings. The United Nations (see Illicit Traffic in Cocaine) reports an increase in international traffic, with the United States the principal importer or victim country. Cocaine sources are Bolivia, Colombia, and Peru; smuggling from France and over the Mexican border is reported. Lawful importing also takes place for pharmaceutical industry processing. In 1963, according to Federal Bureau of Narcotics data (prepared by the California Bureau of Narcotics Enforcement) about 1,436,666 individual doses of cocaine were distributed to hospitals and physicians for use with patients. In the absence of additional data, it would appear that the medical use of cocaine is not associated at present with the development of any large number of cocaine-dependent persons.

Lewin in his early work and later Kolb have both attributed violent crimes to cocaine users, noting that the probable stimulating or excitement-producing effects of the drug on unstable persons are associated with loss of good judgment and with heightened aggressivity; combined with paranoid (persecutory) ideas, crimes against persons are said to be a cocaine user's risk. The difficulty in generalizing from clinical cases is that addiction hospital physicians, like police officers, see the bad cases, persons whose behavior has led them to being apprehended. Other persons using similar drugs who behave normally do not come to the attention of the clinician. It is to be noted that there are no reports of violent crime attendant upon coca leaf chewing by the hundreds of thousands of normal—albeit nearly starved—Andean Indians who chronically use the drug to stave off feelings of cold, hunger, pain, fatigue, and the poor taste of their diet.

In the absence of adequate information we may guess that cocaine use by delinquent persons is associated with delinquent behavior. Insofar as drug effects include impaired mental efficiency or impulse control loss, then their behavior may—when criminal—show these effects. No conclusions about the extent of illicit cocaine use are possible nor can one state any relationship between that use and drug-attributable changes in individual criminality either by type or frequency. It is likely, as with any mind-alterning substance ingested by persons with inadequate personalities who live in social environments which do not provide pressures and rewards for conventional behavior, that drug behavior will be aberrant behavior and will include criminality. Causes are to be sought in the person and his environment as well as in pharmacological effects.

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Appendix A–3

DRUGS, DANGEROUS BEHAVIOR, AND SOCIAL POLICY[1]

by Richard H. Blum

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Our concern in this paper is to consider some issues bearing on social policy vis-a-vis drug use and dangerous behavior. We take policy to be, in a broad sense, the conduct of public affairs; implicit is that the affairs should be handled in a prudent and sagacious manner. Specifically policy is, as Rothwell put it in his introduction to The Policy Sciences (1951), "a body of principle to guide action." For those principles to be established, it is necessary that one know what one's goals are, to know what the situation is in which one is operating, to consider alternative courses toward the goals and to select one on the basis of some set of standards, and to decide upon the means by which the course is to be pursued. Naturally, the implementation of policy presumes that one knows what one's results will be.

It would be fine indeed if this paper could handle the matters under consideration with the neat simplicity of the foregoing program; evolving a principle and recommending not only a course toward clarified goals but particular means; doing so in a fashion which would meet with general acceptance. Were such a feat possible one could be confident that concerted action would follow soon enough.

Unfortunately, matters of fact, of opinion, of morality, and of strategy are not so clear that as of this date one can prepare a policy paper which all good men can approve and certify. When such a policy paper is written, in another area of public concern for example, upon which there is nearly complete agreement, it is likely to describe what has already been done and found to work well, for it is most easily on past actions that wise men can not only agree on the principles but stake their reputations and the welfare of others on the outcomes. New ventures in changing times are less certain. So be it. It is not possible to set up goals and methods which assure results upon which all wise men will agree. This paper will not attempt to do so. It will be addressed to another task, one based on three assumptions.

One assumption is that there is at present considerable disagreement among knowledgeable and well-intentioned persons regarding mind-altering drugs. They disagree on the relationship between drugs and dangerous behavior, disagree on the goals one should have for popular use of drugs, and disagree on their choices of controls over offenses and other kinds of social deviance. There is also disagreement on acceptable alternatives and on the best means to the pursuit of one or another goals. If this assumption is correct we could only be presumptuous in setting a particular course to the exclusion of all others. In doing that we would become advocates for an extant partisan position, an act which is not the same as considering or establishing social policy.

The second assumption is that drug problems are so complex, the state of knowledge so insufficient, and the number of disputes so great that no one paper can effectively attempt to enumerate all of the areas of disagreement, or their arguments, let alone attempt to set a satisfactory course for each. There must be and will be a continuing effort at collecting information, conducting debate, trying and evaluating various kinds of solutions—legislative, educational, medical, social, and the like—before one can say with confidence not only that we "ought" to do such and so, but that "if we do so, we can be sure that such-and-such will be the outcome." To be aware of the process of the slow development of knowledge, decisions, and policy implementation is not to be taken here as counsel for inactivity. As was seen in the discussion and recommendations in the preceding sections of this Report, and as will be seen from the work of other task forces of the President's Commission, a number of immediate steps recommend themselves. These are important and immediately necessary actions, but in themselves are only a body of recommendations. They do not constitute a consistent or integrated policy on drug affairs nor should they be so represented.

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[1] This is one of four papers prepared by Dr. Blum in collaboration with others on mind-altering drugs and dangerous behavior. The introduction to the series appears in the paper on dangerous drugs, printed in this volume as Appendix A–1. A third paper, on narcotics, is printed in this volume as Appendix A–2. The fourth, on alcohol, is printed as an appendix to the Task Force Report on Drunkenness.

A third assumption is that the Nation is in a critical period with regard to policies on drugs and crime; critical in the sense that more powerful drugs are being produced each year, in the sense that offenses are increasing in number and do present a dire threat to well-being, and critical in the sense that citizens are alert and concerned about these developments. Being alert and concerned they are more amenable to, if not demanding of, action at this moment in time than in former years. Information and proposals offered at this time have a higher value than before because people are listening and seeking guidance so that cogent arguments may be expected to have an impact and lead to some measure of controlled change. Some measure we say, for the extent to which any action, by any body of leaders can mold the course of drug use and dangerous behavior in a society as large and swiftly changing as ours remains a dark question. If our third assumption is correct, there is merit in focusing on the issues which divide us to specify at least some of those issues and to point to their implications. We shall be selective. It is not the intent or capability of this paper to analyze all issues or arguments. We shall not review—although we shall return to some of the particular points and recommendations raised in the substantive sections of this report. We shall not make hard and fast recommendations. We shall offer some suggestions for critical discussion, trusting that those with merit will be acted upon at a later date.

Debates on social policy matters regarding drugs and dangerous behavior hinge upon events at least on three levels of discourse or observation. At one level the debate is about, or can be settled by the facts about, drug use per se. For example questions arise about the effects of particular drugs, about the risks of dependency or identification as an addict, and about the role of drugs in causing crimes that would not otherwise occur. Further questions arise about the role of drugs in accidents and suicide, and about the trustworthiness of drug users in the sense of predicting their response to changes in the law or the availability of potentially dependency producing substances. In addition, there are questions about the likelihood of stamping out dependency or addiction—or related dangerous behavior—through harsher laws, through public health clinics and medical care for addicts, or through making drug use itself uncontrolled by criminal law. The previous sections of this report have attempted to set forth such facts as there are. There are no guarantees that the findings to date are either immutable or correct; the probabilities are, however, that they are somewhere "in the ballpark." So it is that if any current debate about the facts of drug use, drug effects, or user characteristics ignores or runs contrary to what is known, then those uninformed or reality-denying advocates do no one any service. There are quite enough areas of real ignorance. No one should have the privilege in a public debate of establishing his own private ignorance as a standard in those areas where something is known.

At this point we shall not attempt to establish as a basis of fact a summary of the findings presented in the earlier sections of this report. A few general statements may, however, serve to anchor later discussion. There is considerable awkwardness in the terminology employed in the drug field; "addict" and "addiction" for example are better abandoned except for the labeling of persons identified publicly as troubled or troubling drug users. The descriptions of classes of drugs can be misleading; no one drug within the ordinary dosage range produces any certain behavioral effect, although there are probable effects which can be stated with increasing accuracy as knowledge about the circumstances of drug administration increases. Implicit here is the fact that persons differ in their reactions to mind-altering drugs according to a large number of contributing factors. There is, consequently, no such thing as a typical drug user nor any one-to-one link between drugs (in normal dosage ranges) and conduct. With reference to troublemaking, most often the people who use drugs and who get into trouble have been in trouble already and would be likely to continue in trouble with or without drugs. A general exception to this occurs with reference to auto accidents when drivers are under the influence of alcohol.

Drug dependency as such occurs, paradoxically, both more often and less often than seems commonly expected; more often in that there is hidden dependency on barbiturates and tranquilizers and especially in the multihabituation pattern where a variety of different drugs are used, no one being essential. Dependency occurs less often in the sense that particular drugs previously thought to be almost inevitably dependency producing, heroin for example, are by no means that, although heavy use over time will produce withdrawal symptoms. Dependency, like becoming an offending addict, depends upon the quality of the person and his environment as well as the way a drug acts upon the body. Of course the availability of a drug, the kind of information there is about it, and the way use is learned are part of that influencing environment; a very important part in terms of predicting later drug behavior.

One critical step in reducing debate about facts, is to separate the phenomena of drug use from that of drug dependency and dependency from that of becoming a visible troublemaker or troubled person (an addict). We suspect that most of the people who try any mind-altering drug, including heroin, do not become dependent on it. We also suspect that an unknown proportion of people who do become dependent on one or another drug do not cause trouble and some are not even troubled by it, at least not remarkably so. Yet drug use, per se, as well as the more extreme drug dependency and the most extreme drug-related trouble is an object of public concern.

There seems to be an ambivalence about the use of any drug, whether aspirin, alcohol, or a sedative, which haunts the heart of even the most solid citizen whose use of such substances could never be termed abuse or potentially troublesome.

The distrust of, perhaps the push-pull ambivalence of wanting and fearing mind-altering drugs, no doubt has other roots. On religious grounds some people may be unwilling to tamper with whatever God has wrought, even if it be sleeplessness or anxiety. That "not tampering" with nature combines respect for what exists with doubt about what might happen, either on earth or perhaps in the affection of the Deity. On cultural grounds drug use is also the subject of ambivalent feelings. In the Anglo-Saxon value system at least, stoicism under pain and "taking it on the chin" are marks of the man. To use a drug can be a sign of weakness, indeed even going to the doctor can be resisted lest it be taken as self-indulgence or the sissy's way out. Similarly our culture, and we use "culture" in the anthropological sense rather than referring to artistic and intellectual interests, has several contradictory ways of looking at pleasure. In Puritan thinking pleasure itself is suspect and the use of any substance to obtain "kicks" or euphoria is evil. The contradiction of course occurs in the nature of man himself who seems to like pleasure well enough to pursue it ardently, sometimes with drugs. The chap who hides a Puritan in his unconscious mind will suffer in his conscience. The very term "drug abuse" is a vivid illustration; it implies depletion, corruption, excess, and improper joy. Certainly judgments of drug abuse rest on no scientific standard unless the scientist is most careful to define what he means. Ordinarily "abuse" is bad in itself and the fact of that conviction should tell us much about the intensity and emotionality of the debate surrounding the use of drugs.

Dependency itself is another area in which the culture provides us with built-in conflicts within ourselves and among one another. Whether one examines welfare programs, farm or airline subsidies, veterans' programs, the quality of relationships among men, or reliance on drugs, both the existence of and criticism of dependent behavior is found. "He shouldn't need a crutch," they say, or "why doesn't he stand on his own two feet?" Yet men are, in varying degrees, not only interdependent but dependent as well. It is not a condition which is in accord with the ideal of individual strength. What can be cultural alternatives (to go on welfare or not, to use drugs heavily or not, etc.) become, inside of the individual, sources of doubt or conflict. We have not found a survey on the topic, but we suspect that many Americans approach their own drug use dubiously, fearful that if they take a sleeping pill they may become dependent, or worrying that their enjoyment of that third martini signals a very bad trend. Whether or not the popularly expressed anger toward and fear of the drug addict as a dependent person reflects, as the more psychologically oriented observer would propose, the public's fears and angers about its own propensities (the addict then being a scapegoat for very personal but nevertheless unadmitted feelings), there can be little doubt that a strong psychological component contributes to attitudes toward drug use. As our own preliminary survey of normal adults indicated (Blum, Braunstein, Stone, 1965, unpublished)[2] the greatest expressed worry about drug dependency is among the people using drugs heavily even though many of the worriers were not apparently dependent. The heavy drug user does not escape these fears, but we suspect that neither does the conventional citizen drinking normally or that same citizen taking pills his doctor prescribes. Given these cultural and personal conflicts about the states to which mind-altering drugs can lead—relief of pain, pleasure, changing the natural or divine order of things, or genuine dependency—it is very likely that a considerable portion of the disagreement about the facts of drug effects and about the means for controlling them reflect personal emotions rather than objective scientific or public welfare considerations. If this be correct, its recognition does not resolve the acrimonious debates one hears, but it does warn those who would make policy that attention to the facts is not sufficient. One must attend to the values and the feelings which color the choice and interpretation of those facts.

Our discussion has moved from the consideration of facts themselves to the feelings and cultural values or themes which divide us. Feelings and morals are not easily assessed and taken into consideration. Nevertheless they exist and strongly so, and their diverse nature makes public agreement more difficult than simply the absence of factual data itself, a condition from which all drug policymakers also suffer. If we are to consider feelings and personal beliefs as a source of disagreement on drug policy, it behooves us to review some of the points or issues upon which citizens may fundamentally disagree. We pose them here as questions. (For a further discussion of some of them see, Blum and Associates, "Utopiates," 1964).

MAJOR ISSUES OF DISAGREEMENT

Individual Rights

Does a person have the right to choose to use a powerful drug to seek some personal or social purpose when there is no approved medical reason for what he does?

> For example, young people taking LSD or marihuana or amphetamines will say that what they want to do among their own friends or inside their own skulls is their own business providing they bring no harm to others and do not offend public taste by being unconventional in public. They argued that others, the police and government included, have no right to invade the privacy of their homes or minds to forbid their seeking artistic or religious or euphoric experiences. Government, they say, is already quite a sufficient "big brother," quite close enough

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[2] References are listed at the end of the paper.

to the all-controlling Orwellian 1984 as it is. May not a man choose his experiences and the means to them?

Inner versus Outer Experience (Anachoresis)

Ours is a social world in which men earn their way and live amongst other men. We contribute ourselves to one another and ordinarily eschew being hermits, mystics, catatonics, misanthropes, or comatose. Does a man have the right to reverse the order and glorify inner experience and become disinterested in the world of other men?

> Some drug users, whether employing marihuana, mescaline, peyote, or heroin, argue that a man has the privilege of withdrawing to seek whatever mysteries, delights, sensations, or simple quiet he can achieve inside himself through drugs, simultaneously withdrawing his interest in and possibly his capacities for ordinary work and family life.

Pleasure

May a man seek pleasure through means disapproved as long as no one else is harmed? May he play while others must work, perhaps even to support him as he becomes a public charge? May he become a chronic hedonist, even though others know—beginning with what hedonist philosophers themselves learned in ancient Greece—that pleasure can be a temptress which turns to pain?

> Some drug users say they seek pleasure and that alone. If they become dependent, pleasure may elude them and drug use continues merely to stave off pain, as for example in avoiding the abstinence syndrome in alcohol, barbiturates, tranquilizers, or opiates. Nevertheless, they often resist the treatment which others think they should have, preferring the pleasures of drugs, however evanescent, to the alternatives of the work-a-day world.

God's will and temperance

Is it the will of God that the flesh not be fulfilled? "Make not provision for the flesh, to fulfill the lusts thereof" it says in Romans 13:14 and again in Romans 14:21–23, "It is good neither to eat flesh, nor to drink wine, nor any thing whereby thy brother stumbleth, or is offended, or made weak * * *. Happy is he that condemneth not himself in the thing which he alloweth."

> The temperance movement, reflected in Fundamentalist beliefs but not limited to Fundamentalists, holds that drinking itself is sinful, not because of excesses, not because of harmful effects, but because there is a moral injunction derived from God. It is an absolutist position based on faith and allowing no relativistic judgments.

Weighing risks

What kinds of bad effects must occur in what proportion of persons using a drug before a decision is made that the drug must be controlled or outlawed?

> Pharmacologists, physicians, the drug industry, and the Food and Drug Adminstration have long wrestled with problems of acceptable potency ratios (LD 50 ED 50 or the dose lethal to 50 percent taking it compared to the dose effective for 50 percent taking it; when LD is very high and ED is very low the drug is safe). No hard and fast rules exist for drugs used to treat somatic disorders; if a drug is effective on a very serious illness (cancer, tuberculosis, dystrophies) and no equivalent remedy exists, one is prepared to accept a higher frequency of side effects and even, in the case of terminal disease, high probabilities of lethal effects, the idea being that one is willing to accept high risks for high gains. But with regard to the psychoactive (mind-altering) drugs, what constitutes high gain and what constitutes high risk and who shall decide what these are and how shall that decision affect marketing the drug? Some tranquilizers which are quite useful in treatment of mental illness produce jaundice-like symptoms and central nervous system (extrapyramidal) symptoms which affect body musculature; yet in treating the mentally ill these side effects are acceptable. Morphine side effects are clearly unpleasant for most patients and yet the drug is widely used. In practice, as long as a person is defined as "ill" and is being cared for by a doctor, controversy over risk-taking occurs but rarely. (When it does it can be dramatic, as in lawsuits over chloromycetin, thalidomide, polio vaccine, etc.)
>
> When drugs are used not to treat agreed-upon illness, but are employed privately (whether self-medicating or not, as might be said for dependent persons taking alcohol or morphine or barbiturates to stave off withdrawal, abstinence, symptoms which will emerge if they stop taking the drug) or socially, then what standards for gain and risk can be employed? With LSD for example which as yet has no proven therapeutic usefulness, its proponents claim high gains in the sense of anxiety reduction, pleasure, artistic or religious experience, or self-understanding. Yet risks include psychosis, panic, multihabituation, and what-have-you, among from 3 to 10 percent of the users, depending upon which population and which measures one is employing. The users say they are willing to accept these risks and don't care if they do "go out of their minds." Observers may insist it is not up to the drug-taker alone to decide, that if he does become "crazy" he will be a public charge in a hospital, will cease being a self-sufficient member of society, may well break up his home and family, and may frighten or conceivably harm others

in the process. Who is to decide what risks a man may take for himself? Are drug risks decisions to have a different base than those in parachute skydiving, cave exploring, or travel in dangerous lands? When a man says it affects himself only but others point out that it is his family which may suffer or the community which must pay for his care, who has the right to decide on weighing risks?

Excess versus Moderation

A fine anthropologist and poet, Ruth Benedict, once described two kinds of cultures: Dionysian or extreme experience cultures and Apollonian or moderation oriented cultures. In the former the emphasis is on intensity, on wild swings between poles of glory and despair, on the pursuit of ecstasy; in the latter the emphasis is on the steady middle course, on control and foresight, on slow ritual and sobriety. As personal or cultural preferences, shall one outlaw the other?

> Benedict used as examples the Northwestern Kwakiutl Indians as Dionysians and the Southwestern Zuni Indians as Appollonians. One might also contrast the technological United States with the more ecstatic Greek culture or, within the United States, the average "sensible" citizen with the "way out" young people who call themselves the "psychedelic crowd," ones who pursue "ecstatic experience" and frequently are users of marihuana, LSD, amphetamines, and the like. One can also describe an ecstatic component in opiate users, for example one study of physician addicts (Modlin and Montes, 1964, p. 363) concluded: "* * * they desire euphoria * * *. They * * * find this part-of-the-time feeling of complete gratification, satiation, wanting for nothing; this episodic tension-free, frustration-free nirvana worth to them whatever price they have to pay." This is as good a description of a Dionysian attitude as any; perhaps similar words are applicable to the madness of young lovers—and other romantics. In contrast, our technological society rests, as the brilliant Max Weber in his "Sociology of Religion" said, on the work-oriented Protestant ethic. That ethic is future based (salvation) and requires rationality, order, self-control, bureaucracy and government, the exaltation of commerce and industry, indifference to religious feeling, but emphasis on religious forms, asceticism, and the rejection of narrow personal loyalties and personal ethics in favor of organizationally determined values. Each of these is a controlled course, a moderate one; in contrast to the feeling-based individual emotional sine curve of the up-and-down course of the ecstacy purser. In a technological society the moderate ethic reigns supreme, for power is in the hands of the producers—which in the United States means most hard-working citizens. The individual who rebels, who is unfit, who is deviant, or who sickens of cold technology and inhuman bureaucracy will want to take another road, often the path of drugs, and whether "drunk" or "high" or "ecstatic" will insist on the excellence of his choice. He may even quote that great American scholar, William James, who, writing on alcohol as a means for achieving religious experience, held that through drinking one found the delicious optimism of grace—as well as falling to the depths of diabolical mysticism.

The foregoing conficts among persons about how life ought to be lived, coupled with the fundamental distrust of dependency paradoxically accompanied by its widespread occurrence, underlie many of the feelings which are exposed during discussion about drug use and what ought to be done about it. In addition to these critical areas, drug policy disagreements arise from differing professional commitments. By professional commitment we mean the point of view which is associated with a particular job. It is an outlook which is learned on the job (and in schooling for the job), partly by experience, partly by the nature of the realities with which one works, and partly derived from personal predispositions which bring one to choose that particular kind of work in the first place. With each commitment to a vocational view there are a set of interlocking beliefs about what are the most important problems, who or what causes those problems, who are best able to deal with them, what solutions proposed by others (outsiders) would only cause more trouble, and so forth.

There are many different vocations whose work requires close contacts with mind-altering drugs or drug users. These include law enforcement personnel working in vice and narcotics control, medical and other healing personnel who use drugs in treatment or who give care to drug users, scientists in universities and government who conduct studies on the causes and consequences of drug dependency (or on the effects of laws about drug use), authorities on criminal and constitutional law, people in the pharmaceutical industry producing and selling drugs, people in the liquor industry, scientists doing basic pharmacological or medical research, government agency personnel charged with drug controls, social and correctional workers, and others involved in nonmedical efforts to prevent or control problem drug use—including related efforts in delinquency and mental health work, temperance people, and other ideological activists including pressure groups trying to legalize marihuana, e.g., the LeMar and the LSD advocates, all of whom act as opinion leaders and lobbyists on drug matters. In addition to these people, whose vocations or ideologies commit them to direct involvement in drug use, there are others whose jobs require their occasional involvement in drug matters; the occasions often being quite important ones. Here one includes legislators, school administrators, traffic safety groups, and public leaders.

It is probable that each vocational group will have different experiences with drugs and drug users, have differing demands made upon it by the people (clients, employers, constituents, etc.) it serves, tend to approach problems in terms of the kind of expertise which it is trained to exercise, and define its interests in differing ways. Within vocational groups there will be considerable variation in points of view, just as there are variations among and between the groups themselves. In consequence of these varying vocational commitments, some of which are strongly opposed to one another, any effort at establishing social policy must not only be aware of the leanings of those groups with most at stake, but must also be aware of their relative power in influencing decision processes. Any effort to modify present programs by developing new social policy must expect to follow the time-honored, practical, American legislative process of (*a*) generating pressure for change, (*b*) participating in the debate over those changes, and (*c*) finally accommodating to a compromise which moves in the direction of needed change without running roughshod over the interests of important existing groups affected by the new policy. It is unfortunate when idealists on drug issues, of whom there are many, equate compromise with either "selling out" or with defeat. It is true that compromise solutions are not as heady as total victory, but total victory on social issues seems to take place only when there is already complete agreement in the first place or when lacking agreement, total power forces decisions. Given diversity of views, the fact of total power in the hands of one faction would be evidence of a democratic failure, since democracy requires the equal sharing of power. To some idealists, whether their ideals are conceived as humanitarian, free enterprise, scientific truth, or traditional morality, the motion of attenuating what they see as the righteousness of their position with the corruption of political process is offensive. Yet it is through political processes, whether in legislatures or outside of them, whereby men seek to meet one another's interest at some point of common ground, that any social policy is established and augmented.

As current "great debates" over mind-altering drug policy, one can point to the following disputes:

1. *LSD*

Should it be prohibited from any but experimental medical use with criminal sanctions for possession for any other purpose or, at the other extreme, should it be freely available to anyone to use as he sees fit. Varying positions are held by law enforcement personnel (for control and punitive laws on possession), medical personnel (mostly for medical but no other use), some academicians, theologians, intellectuals, and artist (for nonmedical use but in some controlled setting), members of the drug movement (for unrestricted use). We admit to overgeneralization; no vocational group has but one position. Our intent is only to establish points on the continuum and to indicate major sources of support.

2. *Marihuana*

Should present criminal statutes under narcotics laws be enforced or, at the other extreme, should marihuana use be legalized so that it becomes an available substance like alcohol or cigarettes? Again one finds (overgeneralizing) law enforcement people at one end, medical and academic people in the middle, and the "drug movement," "new left" and "hip" or "beat" crowd as free-use advocates.

3. *Proprietary Opiates, Tranquilizers, Sedatives, and Stimulants*

New products appear which are useful in reducing pain or anxiety or assisting sleep or altertness. Pharmaceutical houses can claim they are nonaddicting whereas law enforcement and medical people witness dependency among users and call for more stringent controls. Pharmaceutical houses can oppose such controls fearing they will reduce sales. The 1964–65 debate over Percodan is an example; the 1966 debate over meprobamate is another. One can expect future debates over the properties and potentials of the antihistamine sleep aids and tranquilizers. As pharmacological research continues it is inevitable that other mind-altering drugs will be released as safe, but in clinical use (or through further experiments) will be found hazardous. Whenever a high sales volume compound is involved a similar debate may be anticipated.

The more general problem of the proper role of Government in the control of experimentation on and release of medicinal substances is encountered, for the preparation and sale of mind-altering compounds for medical use is but one part of the regulatory picture. There have been recent and serious clashes between the Food and Drug Administration and the pharmaceutical industry regarding the standards to be met before a drug will be certified for prescription use by the FDA. Here the issues range from the design of drug experiments, to the scientific standards to be employed in judging drug effectiveness, to the ethics of subsidies for researchers and policies of publishing adverse effect data. The National Institute of Mental Health has also been subject to congressional, in this case senatorial, scrutiny. Recent Senate subcommittee hearings were critical of the failure of NIMH in past (but not the present) years to support research on the epidemiology of drug use and on other public health studies, as opposed to the more conventional medical research orientation to clinical trials, drug experiments, and the like. Underlying some of the Senate criticism of NIMH was the feeling that a few medical scientists in a few universities and government positions were "backscratching" and confining the majority of grants to an inner circle of persons with a narrow perspective on the needs for drug research. The debate about the choice of research workers (U.S. NIMH fund grantees) as well as choice of projects to support extends to the political, economic, and social problem of the "have" versus "have-not" universities and regions with respect to the presence of scientific talent and the distribution of Federal funds for a variety of research purposes.

4. *Dependency Drug Antagonists*

A number of drugs exist which are active antagonists to other drugs which have dependency-producing potentials. The antagonistic action may work merely to prevent the user enjoying a response to his habitual drug, as long as the antagonist is taken concurrently (as is the case with methadone or cyclazocine given to heroin users). The antagonist may have a more violent effect making the user ill (or killing him) if he takes the habitual drug while the antagonist is present (as in antabuse treatment of alcoholics); it may have only a mild effect signaling the presence of the habitual drug (as in Nalline given to opiate users), or it may be claimed to have a long-term preventive effect by making the user lose interest in his habitual drug. (Heroin was supposed to cure morphine addiction that way. Nowadays LSD is considered by some—the scientific evidence is not yet in—a cure for alcoholism.) In the case of "killer" antagonists such as antabuse, one side says their use is too dangerous; the other says not. Both sides are composed primarily of medical and paramedical healers. In the case of chronic euphoria attenuating substances (methadone) some say it is wrong to feed a drug habit daily, even if the addict no longer is disabled by mental clouding; the dependency itself is not cured and he remains an addict. Opponents answer that opiate dependency is hard to cure anyway and that if one can give a safe medication which allows the user to resume a normal life, then there is nothing wrong with maintaining him on an opiate (which methadone is). Although scientists and drug researchers are primarily involved, the issue of maintaining drug dependency arouses law enforcement and community leaders, church people and other idealistic and pragmatic groups so that they join in the fray.

5. *Heroin and Cocaine*

The great fight here is between those who argue for the present punitive approach to narcotics use—or even harsher law—and those who demand the British system or some equivalent whereby medical practitioners care for drug-dependent persons and where there are no criminal penalties for anything but illicit importation or sales. Narcotic law enforcement officers, particularly the Federal Bureau of Narcotics, are identified with the control through criminal law approach; social scientists, some physicians, and others in both academic and artistic—as well as "drug movement"—circles are in the treat-the-addict-as-a-sick-man group. In between may be found public health people and many nonnarcotics law enforcement personel. Present legislative efforts show a spirit of compromise and a movement in a liberal (medical care) direction. For example, recent House of Representatives passage of the Narcotic Addict Rehabilitation Act allowed addicts charged under Federal law to elect civil commitment to hospital rather than to face trial and imprisonment. This bill, a recommendation from the President's Advisory Commission on Narcotic and Drug Abuse, aroused the ire of some Republican legislators who, in a minority report wrote, "* * * an experimental incursion into uncertain sociological theories * * * to be conducted at the expense of the indispensable principles that those who shall commit crime shall be brought to account * * *." They objected to what they saw as the principle that "the individual is not really responsible for his acts * * * as long as he has indulged himself into dependence on narcotic drugs" (see Science, 1966, vol. 152, June 24, p. 1726).

These comments, and much that has gone before in the debate on handling drug users, reflects fundamental divergency of opinion on the issue of determinism versus free will. That issue underlies much current debate about the criminal law. It asks when men who commit offenses can be deemed responsible if their actions are determined by forces beyond their control, as for example mental or physical disease, and by extension to environmental determinants, for example poverty, an unhappy family life as children, etc. It is considerably beyond the scope of this report to become involved in such an issue with its far-flung scientific, philosophical, medical, legal, and social implications. Suffice it to say that with reference to drug policy those who espouse the disease theory of drug dependency tend to be determinists who advocate nonpunitive handling; those who see men as responsible and self-directing, who see men as capable of foresight and self-control, they are the advocates of punishment as a deterrent and of incarceration as the means to self-correction.

The advocacy of free-choice-and-punishment-for-error on the one side versus beyond-choice-sick-man-needing-help on the other (to simplify) immediately touches other critical issues on a number of levels of thought and action. The criminal law makes a set of basic assumptions the least of which are as follows. It holds, implicitly, that through law governments can control the actions of citizens; that is, that government has both the right to control conduct and that legislation is an effective device for so doing. Since the criminal law relies heavily on penalties (whatever their function, be it to threaten and deter other potential wrongdoers, to express an ideal of conduct, as a means for educating; or as visited upon wrongdoers, vengeance, a desire to change later behavior, or a wish to remove a menace to society) it must presume the effectiveness of punishment in some way to alter human conduct. Finally the operation of criminal law assumes justice, that is to say that its actions will be directed equitably at wrongdoers and will not be adverse to others. Each of these assumptions is open to challenge and each one is challenged by one or another citizen group on the basis of their ideology or their experience. Insofar as these citizens become involved in narcotics policy discussions their general dispositions will affect their particular arguments.

These issues revolving about determinism, about the effectiveness of punishment, and about the more basic capacity of any criminal law substantially to control behavior are by no means all of the points which intrude in discussions of how narcotics addicts are best to be handled. The reader is likely to agree however that these issues are thorny enough to make the establishment of new policies for narcotic addict disposition complex and disputative.

ALCOHOL CONTROL

Most other powerful mind-altering drugs are under stringent legal control which affect their distribution and use. Not so with alcohol, since its controls are relatively benign (dealing primarily with the manner of sale, sale to minors, taxation, etc. except for dry counties and States). Punitive sanctions do apply to addicts, those (mostly men) who get in trouble for drinking, and to those who violate sales laws and the like. Given both the absence and presence of punitive laws and given the great number of persons who are not only drinking but who are also hurt by others drinking (auto accidents especially), one can see a tangle of push-pull efforts both to reduce and to increase alcohol controls. Regarding alcohol there is not one major battle which touches on many moral and social coordinates, as in narcotics, but rather a general struggle spread over time and issues. There are, for example, struggles between the "wets" and the "drys" in prohibition counties and States (with the smugglers and bootleggers often on the side of the drys) to maintain or eliminate local prohibition. There are disputes about the legal drinking age, some wanting to lower it (usually to 18), some to raise it (18 to 21 in those States where it is 18), and others advocating no change. In addition there are disputes over manners of sales, as for example State-licensed liquor stores or other off-premises sales only, versus sales for on-premises use only with food being served, versus sales on premises without food service, or as in California where the Alcohol Beverage Control Board sits as arbiter of public morals, whether or not bare-bosomed waitresses are compatible with the high moral tone of a public drinkery. There are also disputes over where bars may be located, for example how near to schools. In addition there are the intense and wide-ranging battles over the penalties for drunken driving. Despite the high predictability that past drunken drivers will be future drunken killers on the highways, efforts in some States to rescind automatically the licenses of convicted drunk drivers have been mightily and successfully opposed. There has also been the recent court battle over the invasion of privacy posed by the police taking blood samples from drivers suspected of drinking. The blood alcohol level which is to be a standard for proof of drunkenness has long been a matter for argument.

At present there is deep division of opinion about the desirability of criminal sanctions against alcohol addicts (public drunkenness) and, in the courts recently, about the application of statutes prohibiting vagrancy and disorderly conduct against persons who are drunk but otherwise not misbehaving. For example, when public defenders in New York recently challenged drunk prosecutions under the disorderly conduct codes, convictions dropped from 85 percent to 15 percent (Judge Botein, 1966 speech, New York Times). The (national) Cooperative Commission on the Study of Alcoholism will recommend in its forthcoming (1967) report the abolition of all criminal sanctions associated with public drunkenness. In 1966 the Washington, D.C. Crime Commission is also expected to recommend against punitive handling of public inebriety. Another debate has to do with the purpose and use of taxes on alcoholic beverages; some propose tax rates should be very high in order to reduce consumption (notwithstanding the increase in bootlegging which would follow); others claim alcohol tax revenues should be used solely in the prevention and care of alcoholics; others see them as general funds for governmental purposes. A curious and important area of cultural dispute covers the teaching of drinking to the young. On television, for example, beer and wine may be advertised, but beer or wine drinking are rarely if ever shown. The distilled spirits industry does not advertise products on TV at all, apparently fearing an outcry from the temperance people. The role of the schools in teaching about liquor is perhaps as fraught with emotion as in matters of sex education and birth control. Most of those who advocate family instruction of youth in how to drink (culturally integrated drinking) would see value in elementary and high school instruction on the benefits and dangers of alcohol. The opposition to school programs in this area is intense. Again temperance people and those drinking adults whose own approach to alcohol is emotionally charged and ambivalent are in opposition.

Finally, one must call attention to a basic disagreement in which scientists, physicians, and the public are all involved; it has to do with the nature of alcoholism itself. Some, along with Jellinek, consider alcoholism to be an organic disease quite like other medical disorders but one with psychiatric components. Some consider alcoholism a disease, but primarily social and psychological in nature; theirs is a broader mental health approach to illness and social disorder. Others consider alcoholism a weakness, a characterological deficiency, but not a disorder as such and not a condition abrogating individual repsonsibility. Still others think in terms of willful self-indulgence, the gratification of the flesh, and the free choice of sin and evil as opposed to the Christian's choice of the righteous path leading to God's blessing and salvation. These opposing views not only separate interest groups, but occur within individuals to make their positions inconsistent. Plaut (1966, personal communication), reviewing attitude survey data, reports that public opinion polls find the majority of the citizenry willing to consider alcoholism the result of psychological problems; these same citizens when asked about means for cure think not in terms of treatment but mention essentially moral-religious group help, self-improvement programs such as Alcoholics Anonymous. Furthermore, some of these same citizens see no inconsistency in the punitive handling of drunks. Physicians when surveyed (Plaut), ordinarily say that alcoholism is a disease in the medical sense; when their deeper views and actual approaches to the alcoholic are probed, many physicians are found to consider in fact that alcoholism is a character weakness involving moral turpitude, one justifying admonitions, injunctions to "lift yourself out of it, old man" and possibly punitive handling.

DRUGS AND DANGEROUS BEHAVIOR

It would be an oversight indeed if, reviewing the current great debates over policy on mind-altering drugs, one failed to refer to the major questions of fact and the major facts of public feeling regarding the role of drugs in producing dangerous behavior, especially crime. The earlier sections of this report have reviewed as much of the scientific evidence, supporting documentation in the form of testimony before legislative committees, and statistical data based on police reporting as has been possible in the time available. These sections have also alluded to common beliefs, for example, apparently widespread public opinion holding certain drugs inevitably to be addicting (e.g., heroin) and others to be nonaddicting and to be without dependency-producing potentials (e.g., meprobamate, a tranquilizer, or the hallucinogen LSD), and the belief that marihuana or heroin causes loss of control or rationality and subsequent crime, or that addicts per se must necessarily be dangerous to others.

Public Concern

Public beliefs are no doubt shaped by many forces, some of these facts of the kind that scientists generate or confirm, some of the forces being strong emotions which, while very real, may lead to distorted views of the facts of drug effects. In addition, public opinion is no doubt shaped by misinformation received at the hands of the press, various interest groups (narcotics police, temperance people, etc.), from back-fence folklore and the like. It is our impression, not supported by evidence, that public opinion on drug matters does carry a heavy overload of emotion; by overload we mean emotions stronger than those deserved by the facts of extent of drug use and kinds of effects alone. As we indicated in an earlier section, we suspect that the emotions not only reflect personal and cultural conflicts over drug use per se, but reflect very genuine concern about how others do act. People say they are worried about drugs; what they are really worried about is people. The facts are that people do behave badly toward one another, raping, robbing, killing, being unpredictable, and doing all of these terrible things contrary to the morals and rules of our society and ourselves. Furthermore, offenders do these things irrationally, that is contrary to their own long-term best interests. It is difficult to understand why, for behavioral scientists as for anyone else. Our society is undergoing very rapid changes which each day bring us new problems; each citizen is faced with new challenges to his thinking, his adjustment, and which create for him further uncertainty about the future. Some of these changes are in the nature of decreasing the old and familiar ways of dealing with people; more and more strangers are about, the cities are bigger, people are on the move, the younger generation talks of revolution and Negroes speak of "black power." It can all be very unsettling. The facts of life are unsettling too. Crime, at least on the basis of police reports, is on the increase; an increase in violence and property loss considerably more than one would expect from population increases alone. People are afraid. A recent public opinion poll (California, Field poll, June 1966) showed crime and delinquency mentioned as a public problem by more people (a majority in fact) than any other single thing.

When looking for explanations for mystifying human conduct, the "explanations" people arrive at often only point to a scapegoat or shift the mystery to something else. People ask, "I wonder what got into him?" or "What possessed him?" as if it were an outside force that had taken over, since it is painful to imagine an inner force so beastly as to lead to killing eight nurses or shooting dozens of people from a library tower. In ancient Greek drama the answer would have been that a god guided the arm or clouded the eyes of the person, the god being the one who willed the act. In the Middle Ages devils or demons (some of the them demoted Greek gods in historical fact) took over, "it was the Devil that entered him" becoming the answer. But, with modern technology, the Devil is manufactured and has become a drug, instead. "Drug-Crazed Killer Shoots Two" as a newspaper caption example. Or consider the first psychiatrist interviewed after the awful Chicago murders of eight nurses. Without benefit of an interview with the accused (Speck), the good doctor was quoted in the news as saying, "He must have been on drugs." (He was not.)

Factual Risks

The facts as we see them are that some people do get in trouble using drugs and some of those drug users are dangerous to others. Sometimes a drug is a necessary element in order for the person to commit the particular crime he commits, although it may not be causal for his criminality as such. Sometimes a drug does appear to be a critical element disposing the person to commit a crime or other dangerous act—especially accidents, but some suicides as well. Sometimes, on the other hand, the use of a drug seems to be the only convenient excuse by means of which the offender or an observer can account for the unexpected or undesired thing that has happened. And quite often there is no particular reason to believe that the presence of a drug, or of a past habit of drug use, plays any special role in causing the crimes which a man commits.

Depending on where one wants to cut the causal chain, one can establish explanations—and subsequent policy recommendations—in quite different places. Cut the causal chain at one point and one can say that the person as he is and his drug use and his offenses are all the results of past and present forces—the environment, genetics or what-have-you (including modern devils such as poverty). Cut the chain elsewhere and one can say that both the drug use and the choice of crime are consequences or part of, the offender being the person he is, having the personality he does, or being in the situation with the pressures and opportunities it has. Another point in the chain and one can say, as some modern researchers do, that an addict commits more crimes after release from Lexington than before he entered that hospital. Is it heroin, being identified as an addict, Lexington, or something else that will be our explanation (or our modern devil?). No matter how we look at it each point of view should serve to remind us it is (1) a person who uses a drug and a person who commits a crime. We should also be reminded that the much more common case occurs where (2) a person uses a drug and does not commit a crime, or (3) where a person does not use a drug and does commit a crime or (4) does not use a (specified) drug and does not commit a crime. In any event there is a link between drug use, other offenses, and the person himself and it is likely that these links will be very complex and their exact nature will remain uncertain for some time to come. At this point, lest we forget, we should add the fifth most frequent case, epidemiologically speaking, to the foregoing; to wit, (5) nearly all of us are mind-altering drug users and nearly all of us have committed offenses, but very few of us have been identified either as drug-dependent persons or as offenders.

Acceptable Directions for Change

We have considered policy matters and policy dissension arising from the level of fact, the level of morality or life philosophy, and the level of vocational commitment to one or another perspective. We have considered some of the concrete issues about which people are debating and we have taken special note of what we assume to be a particularly important area, that of deep public concern over crime and drug use. We now turn to a further assessment of the attitudes of some important groups. Our focus is on how people may be expected to react to general policy recommendations based upon their present beliefs. The intent is not to argue that policymakers cannot go beyond the positions where the public or interest groups presently stand, far from it; but a policymaker considering innovations had best know the lay of the land.

The Public

Already cited was the public willingness to consider alcoholism as a psychologically determined problem rather than a moral weakness; there was inconsistency, however, in that various moral uplift solutions were seen as appropriate treatments. Unfortunately there is no direct data (that we could find) on public explanations for or treatment proposals for other forms of drug dependency. There is, however, a recent national (July, 1966) Harris survey on public explanations of crime in general and of preferred public solutions. The Harris poll results show most Americans to be environmental determinists; they say the causes of crime are in early environment, broken homes, poor upbringing and the like. Some also attribute crime to mental illness. Only 8 percent spoke in motivational terms, saying people were criminals for "kicks." A few spoke in terms of their being "born bad." These highly deterministic explanations are followed by consistent emphasis on preventive and helpful efforts in crime reduction, as opposed to suppression and punishment. Seventy-six percent favored working with young people as the means to crime reduction, only 16 percent proposed to strengthen the police. Another indication of the willingness of the public to accept less punitive approaches is found in the fact that only 38 percent favor capital punishment; 47 percent are opposed and 15 percent unsure. Finally the pollster asked people what prisons should be like. Only 11 percent said that punishment should be the main purpose of imprisonment; 77 percent favored rehabilitation.

On the basis of these findings one can suggest that policies aimed at prevention of crime—and by extension drug abuse—which emphasize early identification of problem cases, which emphasize improvements in social and home environments, which provide care for the psychologically troubled and which, after offenses are committed, continue to emphasize rehabilitation rather than vengeance will be acceptable to the general public.

A Professional Sample

In the course of a study of LSD users we gathered a group of 47 controls, nonusers who were like the users in age and professional status, etc. (Blum and Associates, 1964). It happened that our user sample was a very respectable and successful, for the most part, professional group; they were our controls. They included professors, mental health professionals, ministers, and the like. We cannot contend that they are representative of professional people, but if we are fortunate, their beliefs will not be greatly at odds with others like them. We discussed drug matters with them at some length (or gave them a detailed questionnaire). We found that most of these "square" controls considered the police as unduly punitive in enforcing drug laws, for example against marihuana use. The majority condemned present punitive narcotics legislation; most wanted more humane handling and greater emphasis on treatment. Only one-sixth wanted stricter controls. Those who were angry about drug issues, rather than being upset with drug users or other narcotic users, were, instead, hostile to the police. Some controls tended, we think quite unfairly, to degrade the knowledge and the humane feelings of the police as a group. In any event, these professionals considered the present criminal laws and the police enforcing them as out of line with desirable social policy.

A Narcotics Officer Sample

In another study (Blum and Wahl, 1964) a small sample of narcotics officers (31 out of many more asked to cooperate) were asked about their views on drug offenders and about ideal dispositions for them. Ranking groups on a scale of menace to the community, heroin addicts were ranked as less of a menace than the Communist Party but more of a menace than syndicated crime, burglary rings, and confidence men. Marihuana users were ranked as less of a menace than ony of the foregoing but more of a menace than the Mafia, white supremicists, crooked real estate operators, and the like. LSD users ranking lower, were more of a menace than the John Birch Society. Asked to recommend ideal punishments for typical offenders, drug peddlers received an average sentence of 6–10 years in prison, the same as given to rapists and armed robbers. Marihuana users along with prostitutes, auto boosters, and income tax evaders were sentenced together for from 1 day to 1 year in jail. LSD users came off more easily, being grouped with common drunks, beatniks, homosexuals, adulterers, and speeding drivers for probation with no time served. Regarding rehabilitation or treatment instead of criminal processing (probation and/or incarceration) up to 40 percent of the officers were willing to see inebriates given (medical) treatment and up to 30 percent recommended that for LSD users. These same officers were asked to describe—from a checklist presented to them—typical users of opiates, of marihuana, and of hallucinogens (LSD, etc.). Heroin users were described as self-indulgent, greedy and insatiable, easily exploited by others, and morally degenerate. Marihuana users were described as disrespectful or rebellious toward authority, exploitative of others, self-indulgent, and abusing sources of pleasure. Hallucinogen users were seen as disrespectful of or rebellious toward authority, as self-indulgent, and as professing superior moral ideas. When asked what the public views were toward users of illegal but presumably nonaddicting drugs (marihuana, LSD), officers most often said the general public was fearful of the spread of drugs in the community, was uninformed, was confused, disgusted at drug practices, and revolted by even nonaddictive illicit drug use effects.

Whether or not the extent of public fear, disgust, and revulsion is as great as the narcotics officers estimate is not known. Their estimates may be taken as reflections of the confidence the officers have that their work has public support. Possibly the emotions attributed to the public are ones also felt by the officers themselves.

It is our impression, not based on formal interview or questionnaire data, but on acquaintance with men who serve as narcotics officers, that they are also aware of the special "publics" who are not in support of a punitive approach to nonmedical drug use, as for example the professional people in our LSD study control group. Some of these officers would be interested in furthering an exchange with professionals to share points of view and to arrive at points of agreement. A few dismiss the professionals and laymen who sympathize with offenders as "do-gooders" or "self-styled experts" (Lindesmith, 1965).

A Legislator Sample

In 1964 we (Blum and Funkhouser, 1965) had the pleasure of conducting a series of interviews with a sample of 50 California State legislators sitting on committees (nearly all of the men sitting on such committees) which processed drug legislation. We were interested in their views on drugs, on what legislation could accomplish, and on the kinds of information sources which they relied upon when considering what action to take. These legislators cannot be assumed to have the same views as their counterparts in other States nor of congressional representatives, but one suspects the same kind of thinking must go on in the minds of any group of elected leaders charged with action in the sensitive issue of drugs. The results of those interviews ought to be carefully considered by persons planning social policy if that policy requires legislative action. For that reason we quote verbatim the summary and conclusions of that study.

> Drug abuse is considered to be a major social threat by the majority of California legislators. Holding key positions of knowledge and power re drug issues, their reaction to this threat, reflected in present law and practice, is to try to influence human conduct through punishment and confinement, measures which are thought to contain rather than solve the problem. Treatment is considered, but for the most part is limited to within-institution programs. Many lawmakers feel that the present approach is inadequate and a few think it inhumane. Although many proposals for new legislation call for more of the same in the sense that harsher laws and stronger controls are advocated, a minority of legislators are actively interested in new approaches. Their willingness to explore and innovate is not reflected, according to the reports of all the legislators, in the opinions of the electorate. The public is generally said to be strongly in favor of punishment and confinement. In their own eyes, a good many legislators are more liberal than the people they represent.
>
> Present positions on legislative alternatives in the handling of drugs and users vary according to the drug under discussion. About LSD, for example, many have no present convictions and are quite open to informed proposals. A hard-core one-third will stand by the present tight control laws. With marihuana, a far milder drug than LSD, but one about which public opinion is strong (and incorrect), present punitive positions are already firm; and for reasons of conviction or political savvy, most legislators would oppose any effort to make marihuana use legal. Concomitantly most lawmakers are quite ready to remove the drunk from police purview provided they are convinced that a treatment program would work and not be too costly.
>
> For those considering new approaches, the choice of sources for information is a matter of real importance. We find that on matters of drugs it is to the medical man, especially to organized medicine,

and to the various law enforcement associations and bureaus that the legislators would turn. Only a few spontaneously consider academic people: Psychologists, sociologists, and psychiatrists. Nevertheless, about half of the legislators in our sample have respect for the potential value of research of human behavior.

As for the relationships between these positions and other variables, we have interested ourselves in the conventional liberal-conservative continuum and in party affiliations. Men who are liberal on drug issues—seek information, are willing to change, are interested in rehabilitation as well as punishment—are also liberal when voting on other social issues: conservatives in drug area are conservative in their other votes. Party affiliation and one's stance as a liberal or conservative are related: most of the conservatives are Republicans; all of the liberals are Democrats. While conservatives and liberals have little in common politically, they do share that strength in conviction which makes them appear more willing than moderates to go it alone against the will of their own constituents.

Although both political stance and party label are consistent with approaches to drug issues, we have found it useful to designate related philosophical positions, namely, moral absolutism and pragmatism. The assumptions implied in these two positions not only help one to understand the extent of the differences between the poles of belief as to how to legislate so as to influence conduct, but these philosophical positions, or personality predilections if one prefers, may prove to be useful variables in research. To illustrate, we have shown that they bear a significant association with the willingness to entertain psychologists, psychiatrists, sociologists, and academic people in general as respected sources of information; absolutists tend to reject, pragmatists to accept, what behavioral scientists might have to say.

The details of the preferred modes of handling drug-dependent persons are worth recording here. The table below presents a breakdown of what the lawmakers told us, separated by political party of the legislators.

Table 1.—Preferred Handling of Drug-Dependent Persons

	N=33 Democrats	N=17 Republicans
Punishment-retribution alone	1	4
Isolation against institutional treatment	16	4
Isolation plus institutional treatment plus punishment-retribution	4	9
Treatment only (no penalties, care, and if need be, maintenance outside an institution)	12	0

We also discussed the various lobbies on drug issues with the lawmakers. They listed the following lobbies as opposing liberal (rehabilitation, no penalty bills) drug legislation: police officials, PTA, mothers' clubs, fraternal societies, other conservative civic groups, the liquor industry, and church and temperance groups. Supporters for liberal legislation were said to be liberal church groups (e.g., the Friends), ACLU, NAACP, social welfare people, and liberal Democratic party action groups. Antitreatment forces were said to be stronger than the rehabilitation-oriented groups (which makes one think on the basis of the Harris poll that it is the antitreatment lobbies which are stronger, not the distribution of actual citizen sentiment). Nevertheless, even the most punitive legislators approved of Synanon—because it costs the taxpayer nothing and emphasizes individual responsibility, withdrawing the addict "cold turkey"—a "no coddling" method of which the more punitive legislators approved. Synanon also had, one observant lawmaker remarked, a very effective public relations program (lobby) in the Capitol. Any social policymaker is well advised to take the Synanon lesson to heart.

Interestingly, even powerful lobbies on drug issues were not said to be of much importance as actual threats to a lawmaker opposing them. As long as there are pressure groups on both sides, then the legislator has a freer hand. Lawmakers observed used or exploited the narcotics issue. Some of their colleagues were seen to "rabble rouse" on drug issues to gain votes. "Narcotics," said one lawmaker, "have been made a political football." Another commented, "We are pushed and pressured * * * by the overexaggeration. Some people discuss it [drugs] as though every other person were addicted." Newspapers and law enforcement lobbies were seen as capable of "whipping up a storm" over lenient drug measures, a storm that could cause trouble.

POSSIBLE POINTS OF AGREEMENT

There can be no question that important differences do exist on drug policy. Any review of published documents, reports, books, tracts, testimony, or speeches provides evidence enough of controversy, the personal experiences of anyone involved in the drug arena (whether as a professional, an observer, or an offender) will be immediate and vivid further proof. Nevertheless, there are areas where agreement rather than disagreement may be forthcoming; these are the areas where immediate social policy objectives can be set. Agreement is defined here in the political sense; it does not imply the absence of any objections or of contrary positions; it does imply that the opposition is not strong and further that the objectors themselves would not suffer any threat to their welfare or self-interest should the policies they oppose be implemented. Points of agreement are as follows.

1. Mind-altering drug use in the United States is nearly universal, most of it by individuals without causing danger to others. One speaks here of common drugs ranging from the mild analgesics (aspirin) and stimulants (coffee, tea) through medically prescribed tranquilizers, sedatives (amphetamine), stimulants and strong pain killers (morphine, anesthetics) to include popular social drugs such as alcohol and tobacco, and

illicit but relatively harmless (as presently used) social drugs such as marihuana and peyote, but necessarily extending to problem drugs such as illicitly employed opiates, hallucinogens, stimulants, sedatives, volatile intoxicants, and others.

2. Users of mind-altering drugs can suffer serious consequences to themselves when problem or dependent use arises. They can also suffer from one-time or episodic use even if a problem has not existed before. In the first instance one speaks of chronic alcoholics, heroin addicts, hidden barbiturate dependent persons, etc. In the second instance one refers to psychoses developing from amphetamine or LSD use, acute toxic effects from alcohol, toxic effects from volatile intoxicants, overdoses (suicidal or accidental) of barbiturates, tranquilizers, etc.

3. Some drug users engage in dangerous behavior—harmful to others—which would not have occurred had not the drug habit or the drug itself been present. One refers to accident-causing drivers under alcohol influence, to loss of impulse control under alcohol associated with violent crime, probably to some opiate addict career crime and the minor criminality of older alcoholics living in an habitual or petty criminal atmosphere, to some LSD aberrant behavior, etc. One must also cite the possible cases of dangerous behavior occurring because a drug is momentarily absent, as in the shaky or near-DT's driver unable to manage a vehicle during alcohol withdrawal, the nervous "junkie" firing his weapon during a mild abstinence syndrome holdup, etc.

4. It is important to protect both the persons suffering—or likely to suffer—from drug abuse from the consequences of their acts and it is important to protect others who might be harmed by drug users. Protection implies government intervention. The problem is serious enough (given the estimates on the prevalence of addicts, relation of alcohol to accident and homicide, association of heroin use to career crime, frequency of barbiturate suicides, etc.) to justify major action programs on a variety of fronts.

BARRIERS TO AGREEMENT

1. There is no agreement on an overall policy of how best to prevent drug abuse from beginning, how best to control the under-the-influence conduct of users, or how best to correct (prevent, treat, etc.) the identified problem drug user. There is also considerable disagreement on related problem areas of taxation, manner of sales, and a variety of other points earlier alluded to.

2. From the standpoint of aesthetics, an innate sense of fairness or commitment to one type of solution, many persons call for wholly consistent drug policies where action is derived from one guiding principle (temperance, punitive laws, individual freedom, equate sanctions with the power of the drug, e.g., reduce controls on marihuana and increase them on alcohol, etc.). Idealistic as each of these proposals is, the present diversity of views is so great that any all-encompassing policy decision covering all mind-altering drugs, or all forms of addition, or all drug legislation must be considered premature. Debate and experiments bearing on these issues are warranted, but it is premature to expect that overall social policy can be established in a climate of intense dispute; any attempt to impose an overriding policy—unless stated in exceedingly high-sounding but otherwise meaningless words—will only serve to heighten conflict and to further reduce possibilities of immediate agreement.

AREAS FOR ACTION

Education and Educational Pilot Projects

1. Risks associated with drug use are in part associated with the kind of settings in which attitudes about drugs are learned, the kind of information available about the drug, and the controls present in the situation where the drug is employed. Control of such risks may be achieved by educating people how to use and how not to use drugs. Programs of education for elementary school, high school, and college students are in order. As initial steps one needs to organize the factual materials for presentation, do research on which presentation methods for what kinds of audiences are associated with information acceptance and attitude change, and develop methods for evaluation of impact on behavior. An important goal would be the development of matter-of-fact views toward drug effects (gains and risks) and of group standards for behavior.

2. Persons who dispense drugs or who have responsibility for the care of others are in important positions for transmitting information, instituting safeguards, and observing behavior so that persons heading for trouble can be identified and, once identified, guided to help. Parents, teachers, employers, physicians, nurses, recreation workers, drug researchers, barkeepers, social workers, etc., all occupy positions as possible drug behavior monitors. These people must be informed about drug facts, warned of risks, given help in identifying persons in danger of suffering bad effects, and given information on the routes for referral to treatment centers or other appropriate control agencies. Experimental programs are needed to learn how best to reach these audiences.

3. Policymakers, lawmakers in particular, are besieged by groups with intense and exaggerated demands for often undesirable drug programs. Misinformation may play a role in shaping some of the misconceptions held by such groups. Information campaigns to the public can be useful not only in presenting facts admitting to uncertainty and correcting false opinions, but also in creating a background climate for the self-controlled use of drugs.

4. Present education as it is offered in sensational stories in the mass media and in some government documents can only serve further to misinform and to add to the load of inappropriate public emotions which charge drug issues. Special programs can be developed and directed to journalists, writers, and to those preparing government documents, the aim of which will be to request moderation, to offer the aid of expert panels in the preparation of material, and periodically to send out summaries of the latest accepted findings in science, recent

legislative trends, new police statistics, etc. Lest there be concern at any government attempts to manage the news, it would be better if such efforts came from private and unimpeachable, no-ax-to-grind groups.

The Impact of the Law

1. Legislators are often uncertain about how laws can affect human conduct. In the drug field there is particular need to know about this since some scientists claim that punitive laws themselves generate a new class of criminals as the result of arrests and convictions. Neither the claims of the sociologists nor the counter claims of prosecutors can be proven. Studies by legal scholars and social scientists are much in order to learn what aspects of drug and of criminal behavior can be affected—and in what ways—by legislative action.

2. The purposes of the law are many-fold; in criminal areas the hope to affect offender behavior is only one facet. Quite likely the public pressure for the enactment of laws, regardless of real effect, serves an important role. One must learn what are the psychological functions of the various legal approaches advocated for drug control. It would also be well to learn how these psychological functions of the law are related to individual morality, conceptions of sources of menace to oneself and the community, and to individual propensities to criminal conduct. In any event, and with reference to possible future changes in laws affecting drug use, if punitive laws are shown to make citizens feel safer (regardless of the impact on crime) one will do the citizen no service by changing the law without first finding other means to secure that citizen's sense of safety.

Directions for Policy

1. The assumption accepted here is that our society is so large, its elements so diverse, and change so rapid, that individuals cannot be expected to have all of the information needed to enable them to guide their own conduct in ways which serve their own self-interest and that of others as well. It is further assumed that given the present technological age that a number of citizens (perhaps an increasing number) will suffer ill effects from social change; those effects crippling their own capacities for rational or perhaps humane behavior. Both assumptions lead to the acceptance of a governmental role in (*a*) factfinding through research and data gathering, and information dissemination to the public, (*b*) alleviating the distress of groups and individuals, (*c*) controlling the harmful behavior of persons through police services. As a matter of policy, drugs themselves should continue under the purview of the law and should be the subject of increasing attention as new drugs are produced and expanded drug use occurs; both of these events being deemed inevitable. Government services under (*a*), (*b*) and (*c*) above will require augmentation.

2. Government involvement in drug matters does not imply emphasis on criminal sanctions alone, nor does it imply any continuing superiority of the judgment of bureaucrats and experts over those of individual citizens. Although government intervention is required, its aim should be educational and rehabilitative so that individual potentials for self-direction are expanded. Only those individuals who bring harm to themselves or others must be controlled. This means that there must be toleration of deviant behavior even if that behavior is contrary to certain traditional standards. The lines are difficult to draw, since it is quite possible that what begins as nonharmful deviant behavior carries within it the potential for destructive later conduct. For these reasons continuous objective evaluation of the relationship of deviant behavior with regard to drug use (e.g., LSD experimentation), and its later outcome in terms of actual risks must be conducted. At present our risk data for many drugs is so inadequate that any approval or control of the social use of these drugs is premature. Here, if anywhere, a crash program of government-supported factfinding is necessary.

General public and much professional sentiment favors expanded emphasis on the treatment of, rather than punishment of, offenders whose offenses are limited to use in violation of drug laws. Recent judiciary action and comments imply agreement. Particular laws such as the inappropriately harsh marihuana statutes are in disfavor among an increasing number of informed persons. Given the recent action of the House in passing H.R. 9176, given similar civil commitment of addicts advocated elsewhere, given survey findings showing public preference for treatment-oriented programs, it would appear that enough sentiment now exists to make it politically possible, as well as humanely desirable, to expand experimental programs for the nonpunitive handling of drug law offenders. With regard to marihuana in particular, an informed debate should begin aimed at reducing the severity of punishments for use of this drug. Similarly the precipitous action of several States of making LSD possession felonious might well be subject to public reexamination in the light of the Federal (FDA) codes. In the alcohol field the recommendations of the Cooperative Commission seek noncriminal handling of public drunkenness. These recommendations deserve public attention and informed debate. The success of Synanon (a self-help private method for treating some heroin users), in gaining support of even punishment-minded legislators may be a useful example for others considering how to gain a wider base of support for similar programs. (The opposition of some law enforcement and corrections people to Synanon can also serve as an illustration of how Synanon has failed. That should point up the importance of working with law enforcement and correctional groups.)

Traffic Accident Reduction

One expects that in the near future there will be greatly increased attention to means for reducing traffic accidents. Control of the drinking driver must figure in these efforts. Experiments in casework with identified drunk drivers and their families and employers may be in order. In order also will be consideration of legislative endeavors to prevent any driving by persons convicted of drunk driving until their alcohol problem can be shown to be cured. Other controls on nonalcoholic but drinking drivers must also be considered.

Finding Problem Users of Drugs

In epidemiology one tries to find cases of a disorder in order to see how many exist, what caused their problems, how their lives evolve, etc. In the drug field, except for recent excellent alcohol-use studies, there is minimal information about drug use and drug problems among the general population. The National Institutes of Mental Health Psychopharmacology Center plans to finance a study in the near future. This work and much more like it deserves much support. Only through such work can we assess the extent and dimensions of our drug use problem.

Case-finding can also be put to practical use. Since problem drug use, drug dependency, or aberrent delinquent behavior in association with drugs is a sign of personal—and often social—disorder, the earliest possible identification of problem drug users is to be sought. These are the people who are most likely to hurt themselves and/or others. If they can be identified before disasters occur, one can exert efforts to treat them individually, to alert those around them to assist in their care, and—to alert community agencies to the emerging problem. The education of "gatekeepers" who dispense drugs or are in a position to observe changes in conduct is indispensible. So is the provision of guidance services, as for example consultation services to schools, social agencies, nurses, etc., on the model of community psychiatric services. Other procedures for identifying drug problem cases must also be developed and assured means put into operation for coordinating the care of such identified persons.

Assisting the Police and the Judiciary

The police are not only first line case-finders for troublemaking or troubled people, they are also under pressure to prevent crime in general and to prevent drug addiction in particular through suppression of illicit drug use and sales. These are all impossible tasks, for the police cannot control behavior prior to its occurrence nor can they suppress the private needs and vices of individuals. (See Report on Police Field Procedures—Police Procedures Advisory Group.) The report on narcotics contains a discussion of the "bind" the police are in when asked to control the private behavior of vice and at the same time not to invade privacy (in a constitutional sense). A variety of charges are hurled at the police from concerned citizens and officials, some of the charges (use of informers, buying dope, using wiretaps, etc.) quite accurate. What is overlooked is that police conduct is the consequence, at least in part, of the immense task put upon them. (E.g., the police do need high penalties on drug use as a bargaining device to induce addicts to inform on sellers in return for informally granted immunity. See Skolnick, 1966). There exists a desperate need to reexamine the demands made on the police by the law and by the public; that reexamination should be conducted with the police as participants. A critical feature requires efforts at rapproachement between the police and the higher courts—at present (See Blum and Osterloh, 1966) the gulf arising from police conduct versus court decisions is deep and serious, not as affecting the police "making" their cases, but as affecting police morale and their view of the intent of the courts. Some have suggested (Packer for example) that the legislature must step into the breach to extricate the courts from the unhappy task of giving the police guidance after the fact. We are not competent to recommend specific actions in terms of the legislative-judiciary relationship; we most certainly can recommend an intensified "dialogue" between the police and the courts, not after the bad cases but to provide everyone concerned morale-saving, respect-enhancing, problem-preventing, perspective. Since many of the bad cases which the police take to be adverse center about drug arrests, the whole process of drug use control is important in the serious division among participants in the process of the administration of justice.

Preventing Social and Personal Disorder

It is evident that most of the criminal behavior attributed to drug users occurs among persons from big city lower class background; this is true for heroin and alcohol addicts. Perhaps similar relationships hold for problem drinkers causing accidents and for drug users committing suicide. An additional number of problem drug users who do not come from big city slums or from other culturally unintegrated groups reflect serious psychological disorders suggestive of unwholesome early family life. The link between social and psychological disorders, drug abuse and subsequent dangerous behavior under drugs is very strong. Any programs directed toward the prevention of poverty and despair, the elevation of deprived minorities and outgroups to full participant status, and the prevention of individual mental disorder, strike at the heart of drug abuse and dangerous behavior.

Creative social experiments, thoughtful scientific work, economic and educational development programs, all deserve support and encouragement. We must be prepared to accept the fact that some will fail, others will achieve only moderate success and, in our lifetimes at least, none will eliminate human ugliness or unhappiness. But to strive toward these goals is our common objective and to achieve them, even in part, should be a satisfaction all of us can share.

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PROPOSALS FOR DANGEROUS DRUG LEGISLATION

by Michael P. Rosenthal

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INTRODUCTION *

While the use of drugs for purposes which we in the United States would deem nonmedicinal is of ancient origin, until recently interest in problems of drug abuse in this country centered almost exclusively on the abuse of the opiates, synthetic opiate-like substances, cocaine, and marihuana.

The focus of concern is now broader. Abuse of heroin and of marihuana obviously continue to be matters of intense concern to public officials, physicians and researchers, sociologists and social workers, and people in all avenues of life, but interest has spread to other drugs. These drugs are a nebulous group. They include drugs which are primarily central nervous system depressants, primarily central nervous system stimulants, and drugs which are known as hallucinogens.

Some of the drugs involved are widely used in medical practice and are beneficial when taken pursuant to medical instruction, but can have dangerous or undesirable effects when taken in extratherapeutic amounts. Others have in this country no medical uses other than experimental use in research. Among the first group would be barbiturates (primarily a group of depressants), amphetamines (primarily a group of stimulants), and some sedatives and so-called tranquilizers which differ from barbiturates in chemical structure but which apparently have effects on the central nervous system in some respects similar to barbiturates. These last-mentioned drugs are known in medical circles as barbiturate-like central nervous system (CNS) depressants. Among the drugs which at present have no significant medical utility are most of the hallucinogens such as LSD, peyote, nutmeg, and morning glory seeds, as well as marihuana.

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There are also industrial substances which are used by some persons for their intoxicating effect. Among these substances would be glue and gasoline. Users of such substances are commonly called glue sniffers. More accurately, they have also been called volatile intoxicant sniffers. And although the use of alcohol is legally recognized and socially acceptable in the United States, alcohol too is a dangerous drug.[1]

It may be anticipated that the number of drugs and substances which are capable of being used for purposes other than that for which they were generally intended will probably increase greatly as industrial chemistry and pharmacology continue to develop. It may also be anticipated that there will be persons who so will use them. While little is known about the causes of drug dependence, and while all persons are to some extent "addiction prone" or "addiction susceptible," there are apparently some persons who, whether because of personality, environment, physiology (perhaps), or any combination of these factors, are particularly likely to become drug dependent.[2] It would appear that the percentage of persons using a drug for nonmedical purposes who are "addiction prone" may vary with different drugs, and again depending upon such factors as personality, background, life situation, timing, associations, and perhaps physiology, such persons may be likely to use and become dependent upon particular types of drugs or one or more of any number of types.

Unfortunately, little is known about dangerous drug abuse. Less is known about it even than about opiate abuse. However, extramedical use of dangerous drugs may involve many types of users. Different persons may

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[1] See Maurer and Vogel, Narcotic and Narcotic Addiction 35–36 (2d ed. 1962). It has been estimated that there are at least 5 million alcoholics in the United States. Note, "Alcoholism, public intoxication and the law," 2 Colum. J. of Law & Soc. Prob. 109 and n. 2 (1966). This is viewed as a conservative estimate.

[2] See Chein, Gerard, Lee, and Rosenfeld, The Road to H: Narcotics, Delinquency, and Social Policy, passim, (1964); Wikler, Opiate Addiction 5, 55–56 (1953); Chein and Rosenfeld, "Juvenile narcotics use," 22 L. & C.P. 52, 59–63 (1957); Rasor, "Narcotic addicts; personality characteristics and hospital treatment," in Hoch and Zubin (ed.), Problems of Addiction and Habituation (Proceedings of the 47th Annual Meeting of the American Psychopathological Association—New York City, February 1957) 1, 4 (1958) ("predisposed to addiction"); Winick, "Narcotics addiction and its treatment," 22 L. & C.P. 9, 19, 21 (1957) ("addiction-prone personality"). Compare remarks of Dr. Marie Nyswander, New York Times, Aug. 16, 1966, p. 41, cols. 3 and 4 (there is no such thing as a "drug-addict personality").

use one or a combination of drugs or they may use different drugs at different times in their lives. A person may use one or more of the dangerous drugs in combination with heroin or when he cannot obtain heroin.[3] Some users are more addiction prone or susceptible than others. Some users have no control over their use. These persons may be both psychologically and physically dependent or merely psychologically dependent. Persons who are physically dependent on a drug usually suffer physical symptoms upon withdrawal and, if also psychologically dependent, are often said to be addicted. Persons only psychologically dependent are sometimes said to be habituated. Other users do have control over their use. The patterns of use among such persons may be quite varied, and the following are illustrative only. There may be regular users who can control their use, so-called weekend users who take drugs occasionally or periodically, and experimenters or tasters. A housewife may occasionally secure a few tranquilizers from her pharmacist without a prescription or from a supply intended for another member of her family. Some of these groups overlap and a person may be in more than one.

Different drugs have different effects. Excessive use of barbiturates and nonbarbiturate sedatives may lead to physical dependence.[4] Of course, there may also be psychological dependence on barbiturates. It is generally held that amphetamine use does not lead to physical dependence and that dependence upon amphetamines is essentially psychological.[5] There is some opinion, however, that use of amphetamines in excessive quantities does lead to a not very significant but nonetheless real physical dependence.[6] Use of LSD and peyote have not been shown to lead to physical dependence.[7] Experimental and occasional weekend use of LSD appears to be common,[8] but there may well be some habitual users.[9] As more information becomes available, a different picture may emerge. Moreover, it should be recognized that patterns of use may change, so that it is possible that the incidence of psychological dependence on LSD may increase. This, however, would not be something peculiar to LSD. Certain people can become psychologically dependent on anything. They can become psychologically dependent on food.[10] Of course, people can become psychologically dependent on tobacco and alcohol.[11]

Public and legislative attention has focused on the so-called dangerous drugs, because of reports of abuse, reports of possibilities of abuse, and reports of the consequences of abuse to the individual user, to persons he comes in contact with and to society. For example, in the case of barbiturates (in addition to physical dependence) suicide, accidental death, and behavior much like that of a person under the influence of alcohol have been reported. Involvement of amphetamines in automobile and truck accidents has been widely reported. Amphetamine use has purportedly been associated with violent crime and has been held to have caused temporary psychosis in some persons. Some of the reported risks, however, have probably been exaggerated, and care must be taken to distinguish the reported risks of particular drugs from the verified risks. Professor Blum has addressed himself to this task in his report to the Commission.[12]

Both Congress and many State legislatures have been of the view that the manufacture and distribution of some or all of these drugs should be subject to regulation to the end of reducing their availability for nonmedical purposes without interfering with medical use. In July 1965, Congress enacted the Drug Abuse Control Amendments of 1965 to the Federal Food, Drug, and Cosmetic Act. The adoption of these amendments has already begun to influence State legislation involving dangerous drugs. This development is seen in recently enacted legislation in Virginia,[13] proposed legislation in New Jersey [14] and in a Model State Drug Abuse Control Act which has been prepared by the Federal Food and Drug Administration (FDA), State enforcement officials and representatives of affected industries.

The author was requested to prepare recommendations for State legislation regulating dangerous drug distribution, to examine Federal law to determine if any changes are in order, to make recommendations for public treatment programs for dangerous drug abusers, and to make recommendations with respect to the marihuana laws and the problem of intoxicant sniffing. His study was not to include problems relating to alcohol or to narcotics as defined under the Federal narcotics laws. Since many of the considerations pertaining to treatment programs for addicts or habitual users of depressant or stimulant drugs are similar to those pertaining to treatment of narcotic drug addicts, the author was requested not to make a detailed report in the area but to endorse or qualify, as he felt necessary, the recommendations of Professor Aronowitz, who has made recommendations for public treatment programs for narcotic drug addicts. The author believes, subject to the explanations and qualifications set out later in this report, that Professor Aronowitz's recommendations are applicable also to treatment programs for addicts and habitual users of certain dangerous drugs.

While the author was asked to recommend the outlines of State legislation and of changes in Federal legislation, he was not asked to draft statutory language, and the language in these recommendations is not necessarily intended as statutory language. Since so little is known about drug abuse, the recommendations are in no sense final answers. Additional experience and knowledge may suggest different paths.

The report is in four parts. The first part deals with the regulation of depressants, stimulants, and hallucinogens—known under the Federal act as "depressant and stimulant drugs." The second deals with the regulation of marihuana, the third with the treatment of users of "depressant and stimulant drugs" and marihuana, and the fourth with intoxicant sniffing. Since it is believed that familiarity with existing Federal and State law will make for better understanding of the recommendations for regulation of "depressant and stimulant drugs," a summary of existing law begins below.

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[3] See *e.g.*, notes 273-275 and accompanying text, *infra*.

[4] See note 235 infra.

[5] See note 250 infra.

[6] See note 251 infra.

[7] See note 312 infra.

[8] See note 313 infra.

[9] See note 312 infra.

[10] Maurer and Vogel, Narcotics and Narcotic Addiction 34 (2d ed. 1962).

[11] Id., at 32, 36; Murphy, "The cannabis habit: A review of recent psychiatric literature," 15 Bulletin on Narcotics, Nos. 1, 15, 17 (January-March 1963).

[12] Blum with Balbaky, Mind-Altering Drugs and Dangerous Behavior: A Preliminary Report to the President's Commission on Law Enforcement and Administration of Justice (June 1966) (hereinafter "Blum Report") (Citations are to manuscript).

[13] Va. Code Ann., §§ 54-446.3—.13 (Supp. 1966).

[14] N.J. Assembly No. 548 (introduced Mar. 14, 1966). Since this paper was written the proposed legislation was enacted. New Jersey Laws of 1966, ch. 314.

PART 1: "DEPRESSANT AND STIMULANT DRUGS"

EXISTING FEDERAL LAW

The basic Federal law regulating dangerous drugs was enacted in 1965 in the form of amendments to the Federal Food, Drug, and Cosmetic Act.[15] Administration and enforcement of the law is entrusted to the Food and Drug Administration in the Department of Health, Education, and Welfare. The amendments became effective on February 1, 1966. By the amendments Congress has sought to control the traffic in dangerous drugs predominantly by registration, inspection, and recordkeeping provisions. It has also given the FDA increased powers of inspection, permitted authorized FDA agents to carry firearms, and given them increased search, seizure, and arrest powers. Criminal sanctions are provided for violations of certain provisions. Since the 1965 Act consists of amendments to the Food, Drug, and Cosmetic Act, the criminal provisions take the form of prohibited acts under that act. The amendments apply to drugs in intrastate commerce as well as to drugs in interstate commerce.[16]

COVERAGE

The 1965 amendments apply to "depressant or stimulant drugs." The term is defined to specifically include drugs which contain any quantity of barbituric acid or any of its salts [17] or which contain any quantity of: Amphetamine, any of its optical isomers, any salt of amphetamine, or any salt of an optical isomer of amphetamine.[18] In addition the term covers any derivative of barbituric acid which the Secretary of Health, Education, and Welfare (actually the FDA) has designated under § 502(d) of the Food, Drug, and Cosmetic Act as habit forming [19] and any substance which he has, after investigation, found to be, and by regulation designated, as habit forming because of its stimulant effect on the central nervous system.[20]

The most important aspect of the coverage of the term "depressant or stimulant drugs," however, is found in that part of the definition which includes: [21]

> any drug which contains any quantity of a substance which the Secretary [of Health, Education, and Welfare], after investigation has found to have, and by regulation designates as having, *a potential for abuse* because of its *depressant* or *stimulant* effect on the central nervous system or its hallucinogenic effect. * * *

While the parts of the definition of "depressant or stimulant drug" first mentioned center largely around barbiturates and amphetamines, this part is the most significant because it is capable of growth to include new drugs that may in the future present problems. Only recently the Secretary has designated under it a number of well-known tranquilizers and nonbarbiturate sedatives as well as a number of hallucinogens including peyote and mescaline (the active ingredient of peyote) and LSD.[22] The manufacturers of three of the tranquilizers have challenged the designation, and hearings are currently in progress.[23] Two substances used in the manufacture of LSD—lysergic acid and lysergic acid amide—have also been designated as "depressant or stimulant drugs" under this part of the definition because they have been found by the FDA to be depressants, and because when either is processed to manufacture LSD a "powerful" hallucinogen is created.[24]

The statutory term "depressant or stimulant drug" used to refer to all drugs controlled under the amendments is misleading. It includes drugs which are hallucinogens. It will be used at all times in this report to refer to drugs controlled under the amendments. Drugs which may actually have a depressant effect, such as barbiturates and nonbarbiturate sedatives, or a stimulant effect, such as amphetamines, will be referred to as " 'medically' depressant or stimulant drugs", to contrast them with the hallucinogens. However, even this terminology is not perfect. While marihuana is usually characterized as a mild hallucinogen it generally produces an intoxicating effect similar to alcohol rather than hallucinations.[25]

Barbiturates and amphetamines were mentioned specifically in the amendments because they had been implicated in abuse for some years,[26] and apparently also because they were believed to constitute recognizable families of drugs. The legislative history reveals that Congress deemed it undesirable to name additional individual drugs in the legislation, because naming them might have adverse effects on patients who were receiving them [27] and might have created "an unfair competitive situation with respect to these drugs and other drugs having similar effects but not so specified." [28] In addition, there is some indication that it was believed impractical for Congress to name additional individual drugs.[29] This task was left to the Secretary of Health, Education, and Welfare under the "habit forming" and "potential for abuse" standards. The report of the House Committee on Interstate and Foreign Commerce said of "potential for abuse" that: [30]

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[15] Public Law 89-74, 79 Stat. 226, 89th Cong., 1st sess. (July 15, 1965).

[16] Sec. 2 of the 1965 act states the congressional findings and declaration of policy:

> The Congress hereby finds and declares that there is a widespread illicit traffic in depressant and stimulant drugs moving in or otherwise affecting interstate commerce; that the use of such drugs, when not under the supervision of a licensed practitioner, often endangers safety on the highways (without distinction of interstate and intrastate traffic thereon) and otherwise has become a threat to the public health and safety, making additional regulation of such drugs necessary regardless of the intrastate or interstate origin of such drugs; that in order to make regulation and protection of interstate commerce in such drugs effective, regulation of intrastate commerce is also necessary because, among other things, such drugs, when held for illicit sale, often do not bear labeling showing their place of origin and because in the form in which they are so held or in which they are consumed a determination of their place of origin is often extremely difficult or impossible; and that regulation of interstate commerce without the regulation of intrastate commerce in such drugs, as provided in this act, would discriminate against and adversely affect interstate commerce in such drugs.

Public Law. 89-74, § 2, 79 Stat. 226, 89th Cong., 1st sess. (July 15, 1965).

[17] Food, Drug, and Cosmetic Act, § 201(v)(1), 21 U.S.C., § 321(v)(1).

[18] Sec. 201(v)(2), 21 U.S.C., § 321(v)(2).

[19] Sec. 201(v)(1), 21 U.S.C., § 321(v)(1). Sec. 502(d) of the Food, Drug, and Cosmetic Act (21 U.S.C., § 352(d)) provides in part that a drug is misbranded if it is for use by man and contains any quantity of any chemical derivatives of certain enumerated substances (including barbituric aid) which derivative the Secretary has designated as habit forming and if its label does not disclose its name and the quantity or proportion of the substance as well as the statement "Warning—May be habit forming." The designation "habit forming" under § 502(d) is not limited to drugs whose use may cause physical dependence (with withdrawal symptoms) but includes drugs whose use may lead to psychological dependence only.

[20] Sec. 201(v)(2), 21 U.S.C., § 321(v)(2).

[21] Sec. 201(v)(3), 21 U.S.C., § 321(v)(3). Narcotics as defined in the Federal narcotics laws and marihuana are expressly excluded from the definition of "depressant or stimulant drugs." Ibid.

[22] Federal Register, 21 CFR, § 166.3, Mar. 19, 1966, p. 4679, cols. 2 and 3.

[23] See New York Times, June 28, 1966, p. 50, col. 1.

[24] Federal Register, 21 CFR, § 166.3, May 18, 1966, pp. 7245, cols. 3 and 7246, col. 1 (proposed).

[25] See Blum Report at 5. See also Murphy, "The cannabis habit: a review of recent psychiatric literature," 15 Bulletin on Narcotics, No. 1, 13, 21 (1963).

[26] House Report No. 130 on H.R. 2, 89th Cong., 1st sess., pp. 2, 4, 6-7 (1965) (hereinafter "House Report").

[27] House Report at 5-6.

[28] House Report at 6.

[29] See testimony of Commissioner George P. Larrick of the FDA, Hearings before the Committee on Interstate and Foreign Commerce of the House of Representatives on the Drug Abuse Control Amendments of 1965, pp. 87, 101, 109 (1965) (hereinafter "Hearings"); statement of Dr. V. D. Mattia of Hoffman-LaRoche, Inc., Hearings at 289.

[30] House Report at 7.

[31] Ibid.

[32] Food, Drug, and Cosmetic Act, § 511(g), 21 U.S.C., § 360a(g).

[33] Ibid.

[34] Ibid.

[35] The designation, shortly after the amendments became effective, of a number of CNS depressants and of peyote, mescaline and LSD was made after an advisory committee had been appointed to make recommendations to the Secretary. 21 CFR, § 166.3, Federal Register, Jan. 18, 1966, p. 565, col. 2 (proposed).

[36] Food, Drug, and Cosmetic Act, § 511(f)(1), 21 U.S.C., § 360a(f)(1).

[37] Sec. 511(f)(2)(A), 21 U.S.C., § 360a(f)(2)(A).

[38] Sec. 511(f)(2)(B), 21 U.S.C., § 360a(f)(2)(B).

> It is not intended * * * that a drug's potential for abuse be determined on the basis of the drug's having a potential for isolated or occasional nontherapeutic purposes. The committee feels that a drug's "potential for abuse" should be determined on the basis of its having been demonstrated to have such depressant or stimulant effect on the central nervous system as to make it reasonable to assume that there is a substantial potential for the occurrence of significant diversions from legitimate drug channels, significant use by individuals contrary to professional advice, or substantial capability of creating hazards to the health of the user or the safety of the community.

In rejecting an amendment that would have substituted for the "potential for abuse" test, a test of substantial involvement in drug abuse, the committee stated "that the Secretary * * * should not be required to wait until a number of lives have been destroyed or substantial problems have already arisen before designating a drug as subject to controls of the bill." [31]

The amendments further provide that the Secretary may appoint a committee of experts to advise him as to whether a substance has a depressant, stimulant, or hallucinogenic effect, whether it has a potential for abuse because of such effect, and with respect to other scientific questions involved in the determination of whether the substance should be designated as a "depressant or stimulant drug." [32] Such committees are advisory only.[33] An advisory committee may also be appointed upon the request of "an interested person." [34] To date the FDA has extensively availed itself of the advisory committee device.[35]

Exempted Drugs

In addition to providing that the Secretary may exempt from all or any part of the depressant or stimulant drug controls any "depressant or stimulant drug" when he finds that its regulation "is not necessary for the protection of the public health",[36] the Secretary is required to issue regulations exempting any "depressant or stimulant drug" if it is a drug which may be sold over the counter without prescription under the provisions of the Food, Drug, and Cosmetic Act [37] or if it contains a counteracting substance or substances in sufficient concentration to prevent the drug from being habit forming because of its stimulant effect or from having a potential for abuse because of its depressant, stimulant or hallucinogenic effect.[38]

Over-the-counter drugs and drugs containing counteracting substances were exempted from the coverage of the amendments rather than excluded from the definition of "depressant or stimulant drugs" because it was believed that exemption would relieve the Government of the burden of proving that a drug was not an over-the-counter drug or a drug containing a counteracting substance in prosecutions under the amendments.[39]

REGISTRATION

The 1962 amendments to the Food, Drug, and Cosmetic Act required persons engaged in the manufacture, preparation, propagation, or processing [40] of drugs to register with the FDA annually.[41] These amendments further provided that upon registration, the FDA could assign registrants a registration number.[42] The FDA has done so.[43] The registration is required to provide the name, place of business, and location of all establishments in any State manufacturing drugs.[44]

Under the 1965 amendments manufacturers must also state on their registrations "in such manner as the Secretary may by regulation prescribe" whether they are manufacturing any depressant or stimulant drugs as defined by the amendments.[45]

By virtue of the 1965 amendments wholesalers of depressant and stimulant drugs were for the first time required to register.[46] Similar information is required of them,[47] and they also receive registration numbers.[48] Wholesalers of drugs who are not dealing in "depressant or stimulant drugs" need not register.

The act specifically exempts from its registration requirements retail pharmacies which do not manufacture or compound drugs for sale other than in the regular course of their retail business, practitioners of the healing arts who manufacture or compound drugs solely for use in the course of their professional practice, persons who manufacture or compound solely for use in research, teaching, or chemical analysis and not for sale and "such other classes of persons as the Secretary may by regulation exempt * * * upon a finding that registration * * * is not necessary for the protection of the public health.".[48a] Hospital pharmacies have been exempted by regulation.[48b] Since the registration requirements apply only to manufacturers and wholesalers, other persons lawfully handling depressant or stimulant drugs such as hospitals are not subject to them unless they are also manufacturers or wholesalers as defined in the act.

PROHIBITED ACTS

Manufacture

The 1965 amendments prohibit manufacture of "depressant or stimulant drugs" but exempt from this prohibition registered manufacturers who prepare drugs for distribution to (1) laboratories or research or educational institutions for use in research, teaching or chemical analysis,[49] or (2) to pharmacies, hospitals, clinics, public health agencies, or physicians for ultimate distribution by pharmacists under prescriptions of State-licensed practitioners or by practitioners themselves "in the course of their professional practice."[50] The manufacturer's distribution may be through branch outlets, wholesalers, or by direct shipment.[51]

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[39] Letter from Chairman Harris of the House Commerce Committee to Commissioner Larrick, dated Mar 3, 1965, printed in 111 Cong. Rec. 4297, col. 3 (House) (daily ed. Mar. 9, 1966); FDA staff memorandum to House Commerce Committee, Hearings at 343.

[40] Hereinafter "manufacturers." The term is defined to include "repackaging, or otherwise changing the container, wrapper, or labeling of any drug package in furtherance of the distribution of the drug from the original place of manufacture to the person who makes final delivery or sale to the ultimate customer." Food, Drug, and Cosmetic Act, § 510(a)(1), 21 U.S.C., § 360(a)(1). The 1965 amendments refer to "manufacture, compound, or process," but state that the term refers to "manufacture, preparation, propagation, compounding, or processing," as defined in § 510. Sec. 511(h), 21 U.S.C., § 360a(h).

[41] Act of Oct. 10, 1962, 76 Stat. 794, Food, Drug, and Cosmetic Act, § 510(b), 21 U.S.C., § 360(e).

[42] Act of Oct. 10, 1962, 76 Stat. 794, Food, Drug, and Cosmetic Act, § 510(e), 21 U.S.C., § 360(e).

[43] 21 CFR, § 132.6.

[44] Act of Oct. 10, 1962, 76 Stat. 794, Food, Drug, and Cosmetic Act, § 510(b), 21 U.S.C., § 360(b); 21 CFR § 132.5.

[45] Food, Drug, and Cosmetic Act, § 510(b), 21 U.S.C. § 360(b).

[46] Ibid.

[47] Ibid.

[48] Sec. 510(e), 21 U.S.C § 360(e); 21 CFR, §*132.6.

[48a] Sec. 510(g), 21 U.S.C., § 360(g).

[48b] 21 CFR, § 132.51(b).

[49] Sec. 511(a)(1)(A)(ii), 21 U.S.C., § 360a(a)(1)(A)(ii).

Also exempted from the manufacturing prohibition are (1) suppliers of manufacturers who meet the above qualifications;[52] (2) registered wholesale druggists distributing to such pharmacies, practitioners, laboratories, research or educational institutions, or hospitals, clinics, or public health agencies; (3) pharmacies, practitioners, laboratories, research or educational institutions and hospitals, clinics or public health agencies themselves; (4) Federal and State officers and employees, and officers and employees of State subdivisions while acting in the course of their official duties; (5) employees or agents of any of the above and nurses or other medical technicians under the supervision of licensed practitioners when any of them are acting in the course of their employment or occupation and not for their own account.[53]

Thus, the scheme of the act is to prohibit manufacture and then to exempt specified classes of persons who basically are engaged in manufacture for medical or scientific purposes from that prohibition. These legitimate manufacturers may lawfully manufacture for the purposes specified.

Sale and Other Dispositions

The amendments follow a similar scheme for sale and other dispositions. Dispositions are prohibited except when engaged in by the classes of persons exempted from the manufacturing prohibition when they are acting in the ordinary course of business and, in addition, when engaged in by common and contract carriers and warehousemen and their employees, when their possession is in the ordinary course of business or employment.[54]

Possession

The same scheme is followed with respect to possession.[55] However, the amendments do not prohibit possession by unauthorized persons per se. There is no simple possession offense. They prohibit possession "otherwise than (1) for the personal use of [the possessor] or of a member of his household, or (2) for administration to an animal owned by him or a member of his household."[56] Possession for purposes other than those stated in (1) and (2) above is prohibited unless the possessor is exempted from the prohibition on sale and other dispositions (i.e., those exempted from the manufacturing prohibition plus carriers and warehousemen and their employees acting in the course of employment).[57] The statute specifically provides that in any criminal prosecution the Government has the burden of proving that possession was not for personal or household use or for administration to an animal owned by the possessor or a member of his household.[58]

Other Prohibited Acts

In addition to unauthorized manufacture, unauthorized sale, delivery or other disposition, and unauthorized possession, the following are prohibited acts:

- ☐ failure to register,[59]
- ☐ failure to prepare or obtain, or failure to keep "complete and accurate" records as required by the amendments,
- ☐ refusal to permit access to or copying of such records,
- ☐ refusal to permit inspection or entry to a place that the amendments permit FDA agents to enter and inspect,
- ☐ filling or refilling a prescription in violation of limitations prescribed by the amendments.[60]

Penalties

Prohibited acts under the amendments are punishable as are other prohibited acts under the Food, Drug, and Cosmetic Act. First offenses are misdemeanors and carry a maximum penalty of a year's imprisonment or a fine of $1,000 or both.[61] Second offenders[62] and those who are convicted of violations "with intent to defraud or mislead"[63] are subject to a maximum of 3 years' imprisonment and a $10,000 fine. Sale or any other disposition of a "depressant or stimulant drug" by a person who is 18 years of age or over to a person under the age of 21 is punishable by a maximum term of 2 years' imprisonment and a maximum fine of $5,000;[64] the penalty for second offenders is a maximum of 6 years' imprisonment and a maximum fine of $15,000.[65]

There are no mandatory minimum penalties, and offenders are eligible for probation, suspended sentence, young adult treatment, and parole.

RECORDKEEPING

The amendments subject to their record keeping provisions all persons "manufacturing, compounding, processing, selling, delivering, or otherwise disposing of any depressant or stimulant drug."[66]

An initial inventory of each drug on hand on the effective date of the amendments is required and is to be kept for three years.[67] However, no subsequent inventory is required.

The amendments also require that manufacturers thereafter keep records of the kind and quantity of each controlled drug manufactured, compounded, or processed with the date of manufacture, compounding, or processing and that every person selling, delivering, or otherwise disposing of any such drug must prepare or obtain records of the kind and quantity of (*a*) each controlled drug received, sold, delivered or otherwise disposed of, (*b*) the name and address "and the registration number, if any" of the person from whom the drug was received and the person to whom it was sold or otherwise disposed of, and (*c*) the date of the transaction.[68] Thus, the amendments call for records of manufacture and receipt and of disposition. It is provided that records must be kept for 3 years.

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[50] Sec. 511(a)(1)(A)(i), 21 U.S.C., § 360a(a)(1)(A)(i).
[51] Sec. 511(a)(1)(A), 21 U.S.C., § 360a(a)(1)(A).
[52] Sec. 511(a)(1)(B), 21 U.S.C., § 360a(a)(1)(B).
[53] Sec. 511(a)(2)-(7), 21 U.S.C., § 360a(a)(2)-(7).
[54] Sec. 511(b), 21 U.S.C., § 360a(b).
[55] Sec. 511(c), 21 U.S.C., § 360a(c).
[56] Ibid.
[57] Ibid.
[58] Ibid.
[59] Sec. 301(p), 21 U.S.C., § 331(p).
[60] Sec. 301(q), 21 U.S.C., § 331(q).
[61] Sec. 303(a), 21 U.S.C., § 333(a).
[62] Ibid.
[63] Sec. 303(b), 21 U.S.C., § 333(b).
[64] Sec. 303(a), 21 U.S.C., § 333(a).
[65] Ibid.
[66] Sec. 511(d)(1), 21 U.S.C., § 360a(d)(1).
[67] Ibid.
[68] Ibid.

The amendments specifically state: [69]

> No separate records, nor set form or forms for any of the foregoing records, shall be required as long as records containing the required information are available.

INSPECTION

The amendments do not require that records be forwarded to the FDA. If the FDA desires to inspect them it may do so. All persons required to keep records, as well as any carriers maintaining records,[70] are required, upon written request, to permit FDA agents to have access to and to copy records at reasonable times.[71] Agents, upon presenting appropriate credentials and written notice, are authorized to enter factories, warehouses, vehicles, and establishments where depressant or stimulant drugs are manufactured, compounded, processed, sold, delivered, or otherwise disposed of and "within reasonable limits and in a reasonable manner" to inspect these places as well as pertinent equipment, finished and unfinished material, containers, labeling, and records.[72]

Inspectors are also specifically authorized to inventory depressant or stimulant drug stocks and to obtain samples.[73] Inspection is not to extend to financial data, sales data (other than shipment data), personnel data, or research data.[74]

PRACTITIONERS' EXEMPTION FROM RECORD KEEPING AND INSPECTION REQUIREMENTS

The amendments specifically exempt from their recordkeeping and inspection requirements drugs received, prepared, or administered or dispensed by a licensed practitioner in the course of professional practice: [75]

> unless such practitioner regularly engages in dispensing any such drug or drugs to his patients for which they are charged, either separately or together with charges for other professional services.

The quoted phrase was meant to require recordkeeping of so-called dispensing physicians. Such physicians were seen as in the same position as pharmacies.[76] They compete with pharmacies,[77] and like pharmacies, and unlike physicians who do not dispense drugs or dispense only trial doses or in emergencies, they may dispense considerable quantities of drugs.

The legislative history indicates that other practitioners were exempted from the recordkeeping and inspection provisions because past history showed that physicians and other practitioners were guilty of few violations involving improper dispensing of drugs.[78] While violations involving pharmacists involved only a very small number of the pharmacists in the United States, pharmacies were made subject to the provisions because the number of violations were greater.[79] Subjecting practitioners to the requirements would have caused considerable objection from the affected groups.[80] During the House hearings on the bill (H.R. 2), the FDA took the position it would not object should the House Commerce Committee determine to make the record keeping and inspection requirements applicable to practitioners.[81] The committee, however, did not do so.

PRESCRIPTIONS

The amendments provide that no prescription for a "depressant or stimulant drug" may be filled or refilled more than 6 months after the date of issue, and no such prescription which the prescriber has authoribed to be refilled may be refilled more than five times.[82] However, after 6 months or five refills the prescriber may renew it either in writing or, if it is promptly reduced to writing and filed by the pharmacist filling it, orally.[83]

It should be noted that this provision does not require that prescriptions for depressant or stimulant drugs must be in writing. It does, however, put the burden on the prescriber to permit refills. If he does not explicitly permit refills, the prescription cannot be refilled. Moreover, the number of refills within a 6-month period is limited, and the life of the prescription is limited to a maximum of six months. The prescriber may, of course, provide that it should have a shorter life or for a lesser number of refills. The provision, in effect, requires a medical judgment every 6 months or after the prescription has been refilled five times within a 6-month period that medical need continues.

OTHER PROVISIONS

The 1965 amendments also authorize the Secretary of Health, Education, and Welfare to authorize FDA agents conducting examinations, inspections, or investigations relating to depressant or stimulant drugs to carry firearms, execute and serve search and arrest warrants and make arrests without a warrant for "depressant or stimulant drug" offenses committed in the presence of the agent, or in the case of felonies, when the agent has probable cause to believe that the person arrested has committed or is committing an offense.[84]

The amendments further provide that the FDA may initiate libel proceedings in the United States district court against any "depressant or stimulant drug" which has been the subject of a prohibited act under the amendments, the container of such a drug, and when the manufacturer has committed the offense, against equipment used in manufacturing such a drug.[85]

An authorized agent may execute seizure by process under the libel,[86] and seize before institution of a libel if he has reasonable grounds to believe that the article or articles seized are subject to seizure and condemnation.[87]

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[69] Ibid. Regulations promulgated under the amendments have interpreted this provision. 21 CFR § 166.16(b)(3)(iv), Federal Register, Jan. 27, 1966, p. 1074.

[70] The author has been informed that carriers were not subjected to the recordkeeping requirements of the amendments, because they often do not know the nature of the articles they ship.

[71] Food, Drug, and Cosmetic Act, § 511(d)(2)(A), 21 U.S.C., § 360a(d)(2)(A).

[72] Ibid.

[73] Ibid.

[74] Sec. 511(d)(2)(B), 21 U.S.C., § 360a(d)(2)(B).

[75] Sec. 511(d)(3), 21 U.S.C., § 360a(d)(3).

[76] House Report at 9.

[77] See Ibid.

[78] See statement of Representative Harris of Arkansas, 111 Congressional Record 4307, col. 3 (House) (daily ed. Mar. 9, 1965); testimony of Commissioner Larrick, Hearings at 27–28, 89–90.

[79] See the preceding note.

[80] See testimony of Commissioner Larrick, Hearings at 89–90, 352; testimony of Dr. John Griffith, Director, Oklahoma Mental Health Planning Committee, Hearings at 310.

[81] Testimony of Commissioner Larrick, Hearings at 28, 29.

[82] Food, Drug, and Cosmetic Act, § 511(e); 21 U.S.C., § 360a(e).

[83] Ibid.

[84] Sec. 702(e)(1)–(4), 21 U.S.C., § 372(e)(1)–(4).

[85] Sec. 304(a)(2), 21 U.S.C., § 334(a)(2).

[86] Sec. 304(b), 21 U.S.C. § 334(b).

[87] Sec. 702(e)(5), 21 U.S.C., § 372(e)(5).

RELATIONSHIP BETWEEN STATE AND FEDERAL LAW

The 1965 act specifically provided that "Nothing in this Act shall be construed as authorizing the manufacture, compounding, processing, possession, sale, delivery, or other disposal of any drug in any State in contravention of the laws of such State" and that nothing in the act nor any amendment to it shall be construed as indicating a congressional intent to occupy the field "to the exclusion of any State law dealing with the same subject matter, unless there is a direct and positive conflict between such provision or amendment and such State law so that the two cannot be reconciled or consistently stand together." [88]

EXISTING STATE LAW [89]

Existing State legislation dealing with dangerous drugs is far from uniform. It also is varied in its potential for effective regulation. A few states have no legislation expressly directed to such drugs.[90] In States that do have legislation the drugs subject to control vary. In some States nonmedical distribution and possession are criminal offenses, and certain dangerous drugs may be distributed to patients solely upon a prescription, but there are no recordkeeping, inspection, or other regulatory provisions.[91]

Still other States have adopted versions of the Model State Barbiturate Act drafted under the auspices of the Council on State Governments in 1955. This act bears some similarity to the Federal amendments and presumably was a starting point for the drafting of those amendments. The act covers only barbiturates and other hypnotic or somnifacient drugs. However, some States have extended it to include amphetamines or both amphetamines and other stimulants.[92] In addition to prescription retention,[93] it requires an initial inventory and maintenance (and retention for 2 years) of "detailed, but not necessarily separate, records and inventories relating to drugs manufactured, sold, distributed, and handled" on the part of pharmacists, practitioners, researchers, hospitals, manufacturers, wholesalers, and warehousemen.[94] Enforcement officials are authorized to make inspections and to take inventories.[95] Controlled drugs may be distributed to patients solely on prescription or by practitioners.[96] Prescriptions must be written except in cases of emergency when oral prescriptions are permissible.[97] Practitioners are to confirm oral prescriptions by giving the pharmacist a written prescription within 72 hours after the telephonic order.[98] Sale and possession for nonmedical purposes are prohibited and subject the violator to criminal prosecution.[99] As in the case of almost all State legislation, possession, even for personal use, is unlawful if the drug was obtained through illigitimate (nonmedically oriented) channels.[100] Obtaining or attempting to obtain a drug "by fraud, deceit, misrepresentation, or subterfuge; or by the forgery or alteration of a prescription; or by the use of a false name or the giving of a false address" is also prohibited.[101]

A few States do not have legislation expressly directed to dangerous drugs as the term is here used but have legislation regulating the distribution of all prescription legend drugs. This legislation may be quite rudimentary,[102] or it may, like Ohio's, outline a fairly detailed regulatory scheme.[103] In virtually all States, pharmacy laws require pharmacists to maintain prescription files for a specified period.[104] In a few States such legislation is the only relevant legislation.[105]

Some States have enacted dangerous drug controls which are stricter than the controls imposed by the Federal amendments. Thus, legislation enacted in New York shortly before the enactment of the Federal amendments [106] is closely patterned after the Uniform Narcotic Drug Act and draws heavily on its language. While amendments enacted in July 1966 [107] have eased some requirements, it is in some respects still more restrictive than the Federal law. The New York act provides for licensing of in-State manufacturers and wholesalers, and for certificates of approval for hospitals, laboratories, maternity hospitals and homes, and nursing and old age homes.[108] Applicants for licenses or certificates of approval must furnish proof of good moral character and that "the applicant possesses land, buildings and paraphenalia to carry on properly the business described in his application." [109]

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[88] Public Law 89-74, §§ 10(a), 10(b), 79 Stat. 226, 235, 89th Cong., 1st sess. (July 15, 1965).

[89] Based on material generally available in July 1966.

[90] Hawaii, Montana, and Wyoming.

[91] Ga. Code Ann., § 42-709 (Supp. 1966); Me. Rev. Stat. Ann., ch. 22, § 2210 (Supp. 1965); Mo. Rev. Stat., § 195.240(7) (Supp. 1965); Neb. Rev. Stat., §§ 28-473, 474 (1964); Vt. Stat. Ann., title 18, § 4101(a) (1959). In Nebraska Vermont there is also express provision for the retention by pharmacists of prescriptions for dangerous drugs. Neb. Rev. Stat., § 28-473 (1964); Vt. Stat. Ann., title 18, § 4101(a) (1959). In many states prescriptions for all drugs must be retained.

[92] In Alabama in addition to barbiturates, "amphetamines or drugs having a stimulating effect on the central nervous system or any other drugs of comparable pharmacological action" are controlled. Ala. Code, title 22, § 258(14) (Supp. 1965).

The District of Columbia legislation applies to amphetamines and other drugs which the Commissioners find to be habit forming, excessively stimulating or to have a dangerously toxic, or hypnotic or somnifacient effect on the body of a human or animal, as well as barbiturates. D.C. Code Ann., § 33-701 (1961).

In Florida, "central nervous system stimulants" were added to the coverage of the act. Fla. Stat. Ann., § 404-01 (1960).

In Indiana, the word "barbiturate" was replaced by the words "dangerous drugs." Dangerous drugs are defined as all prescription legend drugs. Ind. Ann. Stat., § 35-3332 (Supp. 1966).

In Kansas, amphetamines and other drugs found to have a dangerous hypnotic, somnifacient, or stimulating effect on the body were added to the coverage of the act. Kan. Gen. Stat. Ann., § 65-2601 (1964).

In Maryland, amphetamines were added to the act. Md. Ann. Code, art. 43, § 3133 (Supp. 1966).

In Mississippi, the barbiturate law was expanded to include stimulant drugs. Miss. Code Ann., § 6831-01 (Supp. 1964).

In Oklahoma, in addition to barbiturates, stimulants are controlled. Okla. Stat. Ann., title 63, § 465.11 (1961).

In South Carolina, the dangerous drug law includes amphetamines, barbiturates and any drug containing "any substance which the State Board of Health and the appropriate Federal authorities have * * * designated as having a potential for abuse because of its depressant or stimulant effect on the central nervous system or its hallucinogenic effect." S.C. Code Ann., ch. 10, title 32, art. 3 (§ 1) (Supp. 1966).

The Texas law applies to all "prescription legend drugs." Tex. Pen. Code, art. 726d (Supp. 1966).

[93] Model State Barbiturate Act, § 4(2) (1955) (reprinted in 9 Bulletin on Narcotics, No. 2, 18 (April–June 1957)).

[94] Id., § 4(1).

[95] Id., § 5.

[96] Id., § 2(5).

[97] Id., § 1(7).

[98] Id., § 2(4).

[99] Id., § 7.

[100] The only States having dangerous drugs and/or barbiturate laws and not punishing possession for one's own use are Alaska, New Hampshire, Utah, and Vermont. Ohio outlaws simple possession of barbiturates but does not outlaw possession of other prescription legend drugs for one's personal use.

[101] Model State Barbiturate Act, § 2(8).

[102] E.g., Wyoming, where prescriptions are regulated generally under the Pharmacy Act. Wyom. Stat. Ann., § 33-307 (1957).

[103] Ohio requires the registration of wholesalers and the licensing of terminal distributors (retailers). Ohio Rev. Code Ann., § 4729.52–.53 (wholesalers), § 4729.54–.55 (terminal distributors) (Page Supp. 1966). To obtain a terminal distributor's license the applicant, like an applicant for a license under the Uniform Narcotic Drug Act or the New York Depressant and Stimulant Drug Control Act, must furnish proof that he or it is "equipped as to land, buildings and equipment to properly carry on the business of a terminal distributor of dangerous drugs." Sec. 4729.55(A) (Page Supp. 1966).

Sec. 4729.59 (Page Supp. 1966) provides that the secretary of the board of pharmacy is to maintain a register of the names, addresses, and the date of registration of both registered wholesalers and licensed terminal distributors. The register is to be open for public examination and inspection at all reasonable times. The board is also to publish or make available to registered wholesalers and licensed distributors no less frequently than once a year a roster giving the names and addresses of registered wholesalers and licensed terminal distributors as well as those persons whose registrations or licenses have been suspended, revoked, or not renewed.

A letter from Dr. Rupert Salisbury, then secretary of the Ohio State Board of Pharmacy to James Vorenberg, Executive Director of the Commission, dated Apr. 13, 1966, states that the board issues an index of registrants and licensees and publishes the required list together with three annual supplements "so that all persons subject to the provisions of the act have an official list of persons from whom they may buy dangerous drugs and persons to whom such drugs may be sold."

However, the Ohio Dangerous Drug Distribution Act has no recordkeeping requirements. Ohio also has a separate barbiturate law (Ohio Rev. Code Ann., §§ 3719.23–.29 (1954 and Page Supp. 1966)), which provides for an initial inventory and for the keeping of commercial records by manufacturers, wholesalers, practitioners, hospitals, and pharmacists.

[104] E.g., N.J. Stat. Ann., § 45: 14–15 (1963); Wash. Rev. Code § 18.64.245 (1957).

[105] Ala. Stat., § 80.300 (1962); Hawaii Rev. Laws, § 71–13 (1955); Wyo. Stat. Ann., § 3307 (1957).

[106] N.Y. Laws of 1965, ch. 323 (June 1, 1965), N.Y. Public Health Law, §§ 3370–3389 (Supp. 1965).

[107] N.Y. Laws of 1966, ch. 868 (July 29, 1966).

Unlike the situation under the Federal amendments, the recordkeeping requirements of the New York Act apply to practitioners.[110] Recordkeeping is also required of manufacturers, wholesalers, hospitals, laboratories, and nursing homes.[111] Regulations promulgated under the act require both an initial and an annual inventory of controlled drugs by all persons lawfully entitled to possess or distribute them.[112]

While as enacted in 1965 the New York law prohibited oral prescriptions,[113] a 1966 amendment permits them if they are followed by a written prescription within 72 hours.[114]

California's scheme of regulation is also fairly restrictive, particularly as it deals with hypnotic drugs (including barbiturates). Every person (except for a practitioner administering to the immediate needs of a patient)[115] distributing hypnotic drugs must obtain a license from the Board of Pharmacy.[116] The licensee is required to furnish an initial inventory to the Board.[117] Distribution of hypnotics, except for distribution to the patient (which must be under a prescription or by a practitioner), must be on official written order forms which are issued, numbered serially, and made available at cost by the Board of Pharmacy.[118] The original and one copy must be sent by the purchaser to the seller.[119] The seller must within 30 days after receipt forward the duplicate to the licensing board under which the purchaser is licensed (e.g., in the case of a physician to the Board of Medical Examiners.).[120] The seller must retain the original, and the purchaser must retain the other copy.[121] All records must be retained for 3 years.[122] The purchase order must show the date, name of seller, the name and quantity of hypnotics ordered, and the signature, license number, and address of the licensee.[123] The scheme is somewhat similar to that employed under the Federal narcotics and marihuana laws.

Only a few States require special licenses or registrations for manufacturers or wholesalers of dangerous drugs.[124] A number of States, however, provide for licensing or registration of manufacturers and/or wholesalers of all drugs or of prescription drugs.[125] The licensee is usually subject to disciplinary proceedings for violations of the statute or rules and regulations promulgated under it.[128] These proceedings can ultimately result in revocation of the license to conduct business.[129] A large number of States, however, have no licensing or registration provisions at all for drug manufacturers or wholesalers.[130] Pharmacists, and practitioners of medicine, dentistry, and veterinary medicine are everywhere licensed.

The drugs within the coverage of State dangerous drug legislation vary. The combinations are many, and the following are illustrations only: barbiturates only;[131] barbiturates and amphetamines;[132] barbiturates and other somnifacient or hypnotic drugs;[133] hypnotics, depressants and stimulants.[134] Only a few statutes, generally the most recent, expressly apply to hallucinogens.[135] Some recent State legislation deals with LSD specifically.[136] Some statutes list particular drugs.[137] Others give the enforcement agency authority to designate drugs having certain characteristics.[138] There is not a complete correlation between the scope of the coverage and the fullness of the regulatory scheme.

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[108] N.Y. Public Health Law, §§ 3375–78. Under a 1966 amendment out-of-State manufacturers who are registered under the Federal act may sell and dispense controlled drugs within New York without obtaining a license if a written record of the transaction is made. N.Y. Laws of 1966, ch. 868, § 3 (July 29, 1966).

[109] N.Y. Public Health Law, § 3377.

[110] Practitioners must keep records of controlled drugs ordered, received, and dispensed other than by prescription. N.Y. Laws of 1966, ch. 868, § 8 (July 29, 1966). As enacted in 1965 the act also required practitioners to keep records of controlled drugs administered or professionally used. N.Y. Laws of 1965, ch. 323, § 1, N.Y. Public Health Law, § 3388–1 (Supp. 1965).

[111] N.Y. Laws of 1965, ch. 323, § 1, N.Y. Public Health Law, § 3388 (Supp. 1965), as amended by N.Y. Laws of 1966, ch. 868, §§ 8, 9 (July 29, 1966). A written record must be kept of sales by manufacturers and wholesalers. N.Y. Public Health Law, § 3380. Manufacturers and wholesalers are also required to keep records of production, receipt, and disposition. Id., at § 3388–2. Pharmacies are to keep records of receipt, disposition, and of all controlled drug preparations that they compound. Id., § 3388–3. Laboratories are to keep records of receipt and disbursement. The records are to show "requisition, receipt at authorized point of use, name of person authorized to control and use such drugs, the date and amount used, and the signature of the user." Id., at § 3388–5. Hospitals and nursing homes are to keep such records as are prescribed by regulation. N.Y. Public Health Law, § 3386–6 (nursing homes); N.Y. Laws of 1966, ch. 868, § 9 (July 29, 1966) (hospitals).

The act specifically provides that "the keeping of a record required by or under Federal laws and regulations relating to depressant or stimulant drugs containing the same information as is specified herein shall constitute compliance" with the recordkeeping provisions of the act. N.Y. Public Health Law, § 3388–7. Regulations issued before the act was amended require manufacturers and wholesalers to maintain records relating to controlled drugs "in a separate file or in such manner as will make them readily available for inspection by authorized" State enforcement agents, and pharmacies to maintain a "separate depressant and stimulant drug prescription file * * *." N.Y. Administrative Rules and Regulations on Depressant and Stimulant Drug Control, §§ 81.82(g) (manufacturers and wholesalers), 81.83(c) (pharmacies) (hereinafter "N.Y. Regs.").

As enacted in 1965 and before amended in 1966 the New York law required that sales by manufacturers and wholesalers be pursuant to written order signed by the person giving the order or an authorized representative. N.Y. Laws of 1965, ch. 323, § 1, N.Y. Public Health Law, § 3382–1 (Supp. 1965). The original was to be given to the seller, and, except in the case of purchases by practitioners, a signed copy was to be retained by the purchaser. Ibid. Also, before the 1966 amendment hospitals were required to keep very extensive and detailed records, accounting for the distribution of controlled drugs from the main point of supply within the hospital, through each substation or ward, to the patient. N.Y. Laws of 1965, ch. 323, § 1, N.Y. Public Health Law § 3388–4 (Supp. 1965). The record at the main point of supply was to be in the form of a running inventory. N.Y. Laws of 1965, ch. 323, § 1, N.Y. Public Health Law, § 3388–4(b) (Supp. 1965).

[112] N.Y. Regs., § 81.87.

[113] N.Y. Laws of 1965, ch. 323, § 1, N.Y. Public Health Law, § 3371–19 (Supp. 1965).

[114] N.Y. Laws of 1966, ch. 868, § 2 (July 29, 1966).

[115] Calif. Business and Professions Code, §§ 4226, 4226.5.

[116] Id., § 4222.

[117] Ibid.

[118] Calif. Business and Professions Code, §§ 4223, 4224.

[119] Id., § 4224.

[120] Ibid.

[121] Ibid.

[122] Ibid., § 4224 also requires all purchasers (except in-State wholesalers) who purchase from out-of-State persons for delivery in California to forward a duplicate of the order to the licensing board under which the purchaser is licensed, forward the original to the seller, and retain the triplicate for 3 years.

[123] Calif. Business and Professions Code, § 4224.

[124] Calif. Business and Professions Code, § 4222 (hypnotics); New York Public Health Law, § 3375.

[125] E.g., Arizona, "registration" of wholesalers and manufacturers, Ariz. Rev. Stat. Ann., § 32–1929 (1956); Connecticut, "registration" of wholesalers and manufacturers, Conn. Gen. Stat. Ann., § 19–210(b) (Supp. 1965); Iowa, wholesaler "license," Iowa Code, § 155.11 (Supp. 1965); Maryland, "registration" of wholesalers for a "license," Md. Code Ann., art. 43, § 269 (1957); Massachusetts, license for sellers (except wholesale druggists and retail pharmacists licensed by the board of pharmacy) and manufacturers, Mass. Gen. Laws Ann., ch. 94, § 187E (Supp. 1965)—license for out-of-State manufacturers, wholesalers, and druggists shipping into the State, Mass. Gen. Laws Ann., ch. 94, § 187F (Supp. 1965); Minnesota, manufacturer and wholesaler "registration," Minn. Stat. Ann., § 151.25 (Supp. 1965); Nevada, manufacturer and wholesaler "registration," Nev. Rev. Stat., § 454.340 (1963); New Jersey, manufacturer and wholesaler "registration," N.J. Stat. Ann., § 24–6B–1 (Supp. 1965); New Mexico, "license" for manufacturers, N. Mex. Stat. Ann., § 67–9–18 (1953); Ohio, wholesaler "registration," Ohio Rev. Code Ann., § 4729.52–.53 (Page Supp. 1966); Oklahoma, manufacturer and wholesaler "license," Okla. Stat., title 63, § 1–1119 (Supp. 1965); Pennsylvania, "registration" of manufacturers and wholesalers, Pa. Stat. Ann., title 35, § 780–11(a) (1964); Rhode Island, manufacturer "license," R.I. Gen. Laws Ann., § 5–19–26 (1956); Utah, "registration" of wholesalers, Utah Code Ann., § 58–17–6 (1953); Virginia, wholesaler or distributor "permit," Va. Code Ann., § 54–425.1 (1958); Washington, manufacturer and wholesaler "license," Wash. Rev. Code, § 18.64.045 (Supp. 1965); West Virginia, "permit" for manufacturers, W. Va. Code Ann., § 2906(3) (1961).

[The next note is 128.]

[128] Iowa Code Ann., § 155.19 (Supp. 1965); Md. Ann. Code, art. 43, § 269 (1957); Mass. Gen. Laws Ann., ch. 94, § 187F (Supp. 1965); Minn. Stat. Ann., § 151–26 (Supp. 1965); Nev. Rev. Stat., § 454–430 (1963); R.I. Gen. Laws Ann., § 5–19–26 (1956); Wash. Rev. Code Ann., § 18.64.045 (Supp. 1965); W. Va. Code Ann., § 2906(3) (1961).

[129] Some State registration provisions are actually licensing provisions in that the registrant may have his registration revoked or suspended for violations of the statutes or rules of the enforcement agency.

E.g., Minnesota law provides that "the board may suspend, revoke, or refuse to renew any such registration if the holder thereof shall have been found guilty of violating any of the provisions of this chapter." Minn. Stat. Ann., § 151.26 (Supp. 1965). Ohio law provides that "the board of pharmacy may suspend, revoke, or refuse to renew any registration certificate issued to a wholesale distributor of dangerous drugs * * * for * * * violating more than once" certain provisions of the statute. Ohio Rev. Code Ann., § 4729.56 (Page Supp. 1966).

[130] Alabama, Alaska, Arkansas, Colorado, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Michigan, Mississippi, Missouri, Montana, Nebraska, New Hampshire, North Carolina, North Dakota, South Carolina, South Dakota, Tennessee, Vermont, Wyoming.

[131] Minn. Stat. Ann., § 152.09 (Supp. 1965); N. Dak. Cent. Code, § 19–19–02 (1960); Vt. Stat. Ann., title 18, § 4101 (1959).

[132] Ark. Stat. Ann., § 82–956.1 (1960); Kan. Gen. Stat. Ann., § 65–2601 (1964); Ky. Rev. Stat., § 217.720 (Supp. 1965); Mich. Comp. Laws, § 18–1101 (Supp. 1965); Wash. Rev. Code, § 69.40.060 (Supp. 1965); W. Va. Code Ann., § 1385 (27) (Supp. 1965).

[133] Del. Code Ann., title 16, § 4901 (1953); Idaho Code Ann., § 37–2401 (1961); Nebr. Rev. Stat., § 28–475 (1964); N. Mex. Stat. Ann., § 54–6–20 (1953).

[134] D.C. Code Ann., § 33–701 (1961) (barbiturates, amphetamines, hypnotics, and stimulants); Miss. Code Ann., § 6831–01 (Supp. 1964) ("barbiturates and stimulants"); Mo. Rev. Stat., § 195–220 (1959) (barbiturates and "stimulants"); Okla. Stat., title 63, § 465.11 (1961) (barbiturates and stimulants).

Except for a New Jersey bill now on the Governor's desk,[139] drugs designated as "depressant or stimulant drugs" under Federal law are not, by virtue of that designation, included automatically under any State laws.[140] However, the Model State Drug Abuse Control Act which is presently being distributed to the States is entirely geared to Federal determinations.[141]. Thus, if a drug is designated as a "depressant or stimulant drug" by the Secretary of Health, Education, and Welfare it will automatically become a "depressant or stimulant drug" under the law of those States which adopt the act. By contrast, there is under the act no authority for State officials to add drugs which do not come within the Federal act. The pending New Jersey legislation also incorporates Federal designations [142] but further provides that the State department of health may designate as a "depressant or stimulant drug" a drug "posing a threat to the public health by virtue of its record of actual abuse within this State because of its depressant or stimulant effect on the central nervous system or its hallucinogenic effect." [143] Recent Virginia legislation closely modeled after the Federal amendments follows the Federal criteria for defining a "depressant or stimulant drug" but provides that the designation is to be made by the State agency;[144] Federal designations are not automatically incorporated. The 1965 New York legislation treats the problem in the same way.[145]

Many States have no recordkeeping requirements other than those dealing with prescriptions. These prescription requirements are found in laws dealing with prescription drugs generally [146] and in laws dealing exclusively with dangerous drugs.[147] In those that do have more extensive recordkeeping requirements, the requirements vary. The Model State Barbiturate Act requires "detailed, but not necessarily separate records and inventories relating to drugs manufactured, purchased, sold, distributed, and handled." [148] Although the recordkeeping requirements of the act apply to practitioners,[149] two jurisdictions which have based their legislation on it have exempted practitioners from these requirements.[150] Over 20 States require practitioners to keep records of some sort.[151]

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[135] E.g., N.Y. Public Health Law, § 3371-1(c); S.C. Code Ann., ch. 10, title 32, § 1(2) (1966); Va. Code Ann., § 54-446.3 (Supp. 1966).

[136] Legislation enacted in California on May 30, 1966, designated LSD and DMT (another hallucinogen) as "restricted dangerous drugs." Calif. Laws of 1966, ch. 110, amending Health and Safety Code, § 11901, and adding Health and Safety Code, § 11916. This subjected them to criminal prohibitions on sale, possession for sale, and simple possession contained in the California Health and Safety Code. The legislation also provided that it did not apply to the investigational use of LSD or DMT, but that it was not intended to authorize "the possession or furnishing by prescription" of LSD or DMT. Legislation subjecting use and possession of LSD, Lysergic Acid, and DMT to criminal penalties was enacted in Nevada on the same day. Act of May 30, 1966, amending Nev. Rev. Stat., ch. 454. The New York Depressant and Stimulant Drug Control Act of 1965 permits the State commissioner of health to designate hallucinogens as controlled drugs under a potential for abuse standard. Simple possession of drugs controlled under the act is a misdemeanor. N.Y. Penal Law, § 1757-*b* 2.

By a 1966 amendment to its narcotic drug laws, Massachusetts has elected to regulate LSD, DMT, and psilocybin as narcotic drugs. Mass. House Bill No. 2615, amending Mass. Gen. Laws, ch. 94, § 197.

Some States have statutes making use, possession, or sale of peyote a crime. E.g., Ariz. Rev. Stat. Ann., § 36-1061 (1956); Calif. Health and Safety Code, § 11500 (peyote is included as a narcotic under California Health and Safety Code, § 11001); Colo. Rev. Stat. Ann., § 48-5-2 (1953); N. Mex. Stat. Ann., § 54-5-16 (1953); N.Y. Penal Law, § 1747-*d*; N.C. Gen. Stat., § 90-88 (1965) (peyote is included as a narcotic under N.C. Gen. Stat., § 90-87 (1965)); N. Dak. Cent. Code, § 19-03-30 (1960). Peyote is a drug which is deemed misbranded if its label does not bear the statement "Warning—May be habit-forming" under many State food and drug acts modeled after the Federal Act. E.g., Kan. Gen. Stat. Ann., § 65-669 (Supp. 1965); Mo. Rev. Stat., § 196.100 (1959); N.J. Rev. Stat., § 24:5-18 (1940); Wash. Rev. Code Ann., 69.04.480 (Supp. 1965).

[137] E.g., Michigan lists barbituric acid or any of its derivatives, chloral hydrate, paraldehyde, amphetamines, Mich. Comp. Laws, § 18.1101 (Supp. 1965). Georgia also sets out specific drugs such as amytal, luminal, veronal, barbital, acid diethyl barbituric, sulfanilimide, prontylin, neoprontosil, phenobarbital, Ga. Code Ann., § 42-709 (Supp. 1966).

[138] E.g., South Carolina controls drugs which the State board of health and Federal authorities designate as having a "potential for abuse" because of their "depressant or stimulant effect on the central nervous system or * * * hallucinogenic effect." S.C. Code Ann., ch. 10, title 32, § 1(2)(c) (1966). In Virginia, a drug is controlled under the statute if the board of pharmacy finds that it has "a potential for abuse because of its depressant or stimulant effect on the central nervous system or its hallucinogenic effect." Va. Code Ann., § 54-446.3 (Supp. 1966). In New York the commissioner of health may designate a drug as having "a potential for abuse because of its depressant or stimulant effect on the central nervous system or its hallucinogenic effect * * *." N.Y. Public Health Law, § 3371-1.

[139] N.J. Assembly No. 548 (introduced Mar. 14, 1966).

[140] In South Carolina the term depressant or stimulant drug is in part defined to include barbiturates, amphetamines, and any drugs which the "State board of health and the appropriate Federal drug authorities * * * have * * * designated as having a potential for abuse because of its depressant or stimulant effect on the central nervous system or its hallucinogenic effect." S.C. Code Ann., ch. 10, title 32, § 1(2) (1966).

[141] Model State Drug Abuse Control Act, § 1(d).

[142] N.J. Assembly No. 548, §§ 1 (a)(1), (2), (3).

[143] Id., § 1(a)(4).

[144] Va. Code Ann., § 54-446.3 (Supp. 1966). Compare the South Carolina legislation in note 140 supra.

[145] N.Y. Public Health Law, § 3371-1.

[146] E.g., Ariz. Rev. Stat. Ann., § 32-1929 (1956); Wash. Rev. Code, § 18.64.245 (1957).

[147] E.g., Nev. Rev. Stat., § 454.360 (1963); Oreg. Rev. Stat., § 475.100(2) (1965); Miss. Code Ann., § 6831-05 (Supp. 1964).

[148] Model State Barbiturate Act, § 4.

[149] Id., §§ 3, 4(1).

[150] Ind. Ann. Stat., § 35-3335 (Supp. 1966); D.C. Code Ann. § 33-705(a)(1961).

[151] Alabama: Initial inventory and retention of commercial or other records. Ala. Code, title 22, § 258(6) (1958).

Arkansas: Record of quantity, character and potency, and of purchase and date of purchase, except no record whatsoever need be kept when amount dispensed in 24 hours does not exceed 8 grains for any one patient. Ark. Stat. Ann., § 82-956.3 (Supp. 1965).

California: Special order purchase forms for most purchases. Calif. Business and Professional Code, § 4224.

Delaware: Name and address and date of dispensation to patient, name and quantity of drug, and record of renewals. Del. Code Ann., title 16, § 4904 (1953).

Florida: Records pertaining to barbiturates. Fla. Stat. Ann., § 404.05 (1960).

Idaho: Initial inventory and retention of commercial or other records. Idaho Code Ann., § 37-2405 (1961).

Illinois: Records of type, quantity, when and from whom received, when and to whom dispensed or sold, with invoice of purchase and prescription sufficing. Ill. Rev. Stat., ch. 111½, § 404 (1966).

Iowa: Name, address, and date of dispensation to patient, amount and type of drug. Iowa, § 203A.9(13) (Supp. 1965).

Kansas: Records as to drugs purchased, sold, distributed, or handled. Kans. Gen. Stat. Ann., § 65-2604 (1964).

Kentucky: Record as to barbiturates received and dispensed (no similar provision under amphetamine law). Ky. Rev. Stat. 217.481 (1963).

Louisiana: Records "pertaining to barbiturates and central nervous system stimulants as may be required by the * * * Board of Pharmacy." La. Rev. Stat., § 40:1036 (1965).

Maryland: Initial inventory, record of barbiturates received; name and address of person to whom dispensed, date of dispensation, name and quantity of barbiturate dispensed (nothing in new amphetamine law applies to practitioners). Md. Ann. Code, art. 43, § 287(b) (1957).

Michigan: Record of dispensation only if patient is not personally attended. Mich. Comp. Laws, § 18.1101(b) (Supp. 1965).

Mississippi: Initial inventory and records of manufacture, purchase, sale, distribution, and handling. Miss. Code Ann., § 6831-05 (Supp. 1964).

Nevada: Requires practitioners to keep record of amount, source, and date of receipt of Lysergic Acid, LSD and DMT, name and address of person to whom dispensed, and kind and quantity of such drugs dispensed. Act of May 30, 1966, amending Nev. Rev. Stat., ch. 454.

New York: Annual inventory (by regulation); record of drugs ordered, received, and dispensed other than by prescription. N.Y. Laws of 1966, ch. 868, § 8 (July 29, 1966).

North Carolina: Retention of invoices, prescriptions, orders, and records relating to drugs manufactured, purchased, sold, or handled. N.C. Gen. Stat., § 90-113.5 (Supp. 1965).

North Dakota: Initial inventory, record of barbiturates received, name, address, and date of dispensation to patient, and name and quantity of drug. N. Dak. Cent. Code, § 19-19-06 (1960).

Ohio: (barbiturate law) initial inventory; retention of "commercial or other" records; record of all barbiturates administered, dispensed, or professionally used otherwise than by prescription (to include name and address of patient); requirement last mentioned inapplicable when amount administered, dispensed, or professionally used in treatment of a single patient does not exceed 12 grains within 48 hours. Ohio Rev. Code Ann., § 3719.26(C) (1953).

Oklahoma: Record of barbiturates or stimulants dispensed, name and quantity of drug, and date and name of dispenser. Okla. Stat. Ann., title 63, § 465.15(b) (1961).

Rhode Island: Initial inventory, retention of commercial or other records, and record of name and address of person to whom dispensed (requirement last mentioned is not applicable when amount distributed to one patient in 48 hours is less than 12 grains of a barbiturate or 60 mg. of a central nervous system stimulant). R.I. Gen. Laws Ann., § 21-29-8 (1956).

South Carolina: Initial inventory; record of drugs purchased; record of drugs dispensed or sold—date, name, and address of person to whom sold or dispensed, kind and quantity of drug sold or dispensed. S.C. Code Ann., ch. 10, title 32, § 4 (1966).

Texas: Initial inventory, retention of commercial or other records. Tex. Pen. Code, art. 726d, § 5 (1961).

Some laws require retention of records but do not specify what information the records must contain.[152] In most States, recordkeeping requirements, whatever they are, may be fulfilled by the keeping of invoices and other commercial records.[153] Neither separate records nor special forms are normally required. California, of course, requires official written orders in triplicate, with copies to the enforcement agency, the seller and the buyer, for hypnotic drugs.[154] Other States do not require official forms, and only a very few require the regulated to send records or to report to the enforcement agency.[155] All States which require retention of records authorize inspection by the enforcement agency to examine and copy the records.[156] A number of States, including those whose legislation is based on the Model State Barbiturate Act require an initial inventory.[157] Only New York and the District of Columbia require periodic inventories, and in New York the requirement was imposed by regulation.[158]

With one exception, State dangerous drug laws permit either oral or written prescriptions. In Vermont prescriptions for barbiturates must be in writing.[159] Sometimes oral prescriptions are permitted only in case of emergency, and, as under the uniform act, the prescriber is sometimes required to furnish a confirming written prescription within a specified period of time.[160] In most States, however, it is sufficient if the pharmacist promptly reduces the oral prescription to writing.[161]

Under every dangerous drug law prescriptions may be issued and drugs administered or dispensed by practitioners solely "in the course of professional practice," or "in the course of * * * profession," or "in good faith." [162] The laws often expressly permit distribution and possession by researchers for research and not for sale.[163] In Arkansas a controlled drug may be prescribed only on the occasion of a personal contact between practitioner and patient.[164]

Most States which have dangerous drug legislation treat sale (and other dispositions) and possession outside of legitimate channels criminally. The penalties vary widely. In some States they are quite light.[165] In others they are heavy.[166] In some States mandatory penalties are imposed, particularly for sales or other dispositions.[167] Sales by adults to juveniles usually result in heavy penalties, some of which carry mandatory minimum terms of imprisonment.[168] These provisions, however, generally do not preclude probation or parole.

A few States punish possession for the purpose of sale or other distribution.[169] In Ohio and North Carolina it is provided that possession without a prescription of a certain number of dosage units of a controlled drug shall be presumptive of prima facie evidence of a violation. In Ohio the quantity is 150.[170] In North Carolina it is 100.[171] Except in Ohio, all of the possession for sale provisions are in addition to simple possession provisions. In Ohio the possession for sale provision is the only posession provision for controlled drugs other than barbiturates. Simple possession of barbiturates is prohibited in Ohio.

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[152] E.g., Florida requires designated persons to keep "records pertaining to barbiturates and central nervous system stimulants." Fla. Stat. Ann., § 404.05 (1960). Louisiana requires retention of "records pertaining to barbiturates or central nervous system stimulants as may be required by the Board of Pharmacy." La. Rev. Stat. Ann., § 40: 1036 (1965). The Ohio barbiturate law provides for the retention of "each commercial or other record relating to barbiturates * * * maintained * * * in the usual course of * * * business or occupation." Ohio Rev. Code Ann., § 3719.26(A) (1953). The Ohio law, however, does contain some detail as to what is required of pharmacists and physicians. Id., § 3719.26 (B), (C).

[153] E.g., Maryland law states "the usual commercial or other records maintained by manufacturers, wholesalers, practitioners or pharmacists, with the exception of the inventory of the initial stock on hand, shall suffice to meet the requirements of this section." Md. Ann. Code art. 43 § 2287(d) (1957). The District of Columbia Code provides that the persons designated shall "retain all such commercial or other records, including invoices, relating to dangerous drugs received or maintained by them in the course of their business or occupation * * *." D.C. Code Ann., § 33–705 (1961). See also the Ohio Barbiturate Law, Ohio Rev. Code Ann., § 3719.26(A) (1953).

[154] Calif. Business and Professions Code, § 4224.

[155] Under Texas law a pharmacy or pharmacist purchasing an amphetamine, or a barbiturate or other hypnotic from an out-of-State person is required to forward copies of the original order to the State board of pharmacy and to the out-of-State person, and to retain a copy. Tex. Pen. Code, art. 726d, § 7 (1961). In New York the statute requires prompt recording of the theft, loss, or destruction of any controlled drug. N.Y. Public Health Law, § 3388–7. In addition, regulations in New York require the preparation of both an initial inventory and annual inventories in duplicate on a form provided by the enforcement agency and that a return be forwarded to the enforcement agency. N.Y. Regs., § 81.87 (1966). The New York regulations also require pharmacies to maintain a "separate depressant and stimulant drug prescription file * * *." Id. at § 81.83(c).

[156] Ala. Code, title 22, § 258(18) (Supp. 1965); Ark. Stat. Ann., § 82–956.2 (Supp. 1965); Conn. Gen. Stat. Rev., 19–237 (1958); D.C. Code Ann., § 33–706 (1961); Idaho Code Ann., § 37--2406 (1961); Ill. Rev. Stat., ch. 111½, § 404 (1966); Iowa Code, § 155.24 (Supp. 1965); Ind. Ann. Stat., § 35–3335 (Supp. 1966); Kans. Gen. Stat. Ann., § 65–2605 (1964); Ky. Rev. Stat., § 217.790, § 217.531 (1963); La. Rev. Stat., § 40: 1037 (1965); Md. Ann. Code, art. 43, § 287(e) (1965); Mich. Comp. Law, § 18.1101(d) (Supp. 1965); Miss. Code Ann., § 6831–06 (Supp. 1964); Nev. Rev. Stat., §§ 454.350, 360 (1963); N. Mex. Stat. Ann., § 54-6–21 (1953); N.C. Gen. Stat., § 90–113.5 (Supp. 1965); N. Dak. Cent. Code, § 19–19–07 (1960); Ohio Rev. Code Ann., § 3719.27 (1953); Okla. Stat. Ann., title 63, § 465.17 (1961); Pa. Stat. Ann., title 35, §§ 780–17(a) (1), (2) (1964); R.I. Gen. Laws Ann., § 21–29–10 (1956); Tex. Pen. Code, art. 726d, § 6(1) (1961); Va. Code Ann., § 54–44.5(b) (Supp. 1966).

[157] Ala. Code, title 22, § 258(17) (Supp. 1965); Calif. Business and Professional Code, § 4222; D.C. Code Ann., § 33–705(a)(1) (1961); Idaho Code Ann., § 37–2405 (1961); Md. Ann. Code, art. 43, § 287(a) (1965); Miss. Code Ann., § 6831–05 (Supp. 1964); N. Dak. Cent. Code, § 19–19–06 (1960); Ohio Rev. Code Ann., § 3719.26(A)(1) (1953); Okla. Stat. Ann., title 63, § 465.15 (1961); R.I. Gen. Laws Ann., § 21–29–8 (1956); S.C. Code Ann., ch. 10, title 32, § 4(a)(1) (1966); Tex. Pen. Code, art. 726d (sec. 5) (1961); Va. Code Ann., § 54–446.5(a) (Supp. 1966).

[157a] N.Y. Regs., § 81.87 (annual); D.C. Code Ann., § 33–705(a)(1) (1961) (biennial).

[158] N.Y. Regs., § 81.87.

[159] Vt. Stat. Ann., title 18, § 4101(a) (1959).

[160] E.g., Ark. Stat. Ann., § 82.956.4 (1960); Idaho Code Ann., § 37–2402(d) (1961); Mass. Gen. Laws Ann., ch. 94, § 187A (Supp. 1965); N. Dak. Cent. Code, § 19–19–03 (1960).

[161] E.g., Colo. Rev. Stat. Ann., § 48–8–2 (Supp. 1960); Ill. Rev. Stat., ch. 111½, § 417(2) (1966); Kans. Gen. Stat. Ann., § 65–2602 (1964); La. Rev. Stat. Ann., § 40: 1032(8) (1965); Md. Ann. Code, art. 43, § 284(G) (1965); Minn. Stat. Ann., § 152.09 (Supp. 1965); N.C. Gen. Stat., § 90–113.1(8) (Supp. 1965); Oreg. Rev. Stat., § 475.100(2) (1965); Pa. Stat. Ann., title 35, § 780–5 (1964); R.I. Gen. Laws Ann., § 21–29–2 (1956); S.C. Code Ann., ch. 10, title 32, § 1(h) (1966); Utah Code Ann., § 58–17–14.8 (1963); W. Va. Code Ann., § 1385(27) (Supp. 1965); Wis. Stat. Ann., § 151.07(9) (1957).

[162] E.g., "In the course of professional practice," D.C. Code Ann., § 33–701(5) (1961); "delivered or administered by a practitioner in good faith and in the course of professional practice," Fla. Stat. Ann., § 404.02 (1960); "delivered by a practitioner in good faith in the course of his practice," Ind. Ann. Stat., § 35–3333A(2) (Supp. 1965). A Washington State statute provides that:

> A prescription, in order to be effective in legalizing the possession of dangerous drugs, must be issued for a legitimate medical purpose by one authorized to prescribe the use of such dangerous drugs. An order purporting to be a prescription issued to an addict or habitual user of dangerous drugs, not in the course of professional treatment is not a prescription within the meaning and intent of this section; and the person who knows or should know that he is filling such an order, as well as the person issuing it, may be charged with violation of this chapter.

Wash. Rev. Code, § 69.40.064 (Supp. 1965). The foregoing provision is similar, but not identical, to a Treasury regulation dealing with narcotic prescriptions. See 26 C.F.R., § 151.392. Compare Mass. Gen. Laws, ch. 94, § 187A (Supp. 1965):

> * * * A [practitioner] may personally administer any harmful drug at such time and under such circumstances as he, in good faith and in the legitimate practice of medicine, believes to be necessary for the alleviation of pain and suffering or for the treatment or alleviation of disease.

[163] E.g., Kans. Gen. Stat. Ann., § 65–2603 (1964); S.C. Code Ann., ch. 10, title 32, § 3(3)(b) (1966); Tex. Pen. Code, art. 726d, § 4(b)(3) (1961).

[164] "It shall be unlawful for any person to procure or possess any of the drugs mentioned in this act except upon the written prescription or personal dispensation of a legally qualified physician made following a personal contact by such physician, such personal contact to be made upon the occasion of the writing of such prescription or the making of each such dispensation." Ark. Stat. Ann., § 82–956.6 (1960).

[165] E.g., Ohio, under its dangerous drug distribution law, punishes both possession for sale and sale with a fine of not less than $100 nor more than $300 for the first offense and not less than $300 nor more than $500 for subsequent offenses. Ohio Rev. Code Ann., § 4729.99 (Page Supp. 1966).

[166] E.g., Under the Mississippi barbiturate and stimulant law both simple possession and sale are punishable by a fine of not more than $1,000 and imprisonment for not more than 5 years for a first offense, a maximum fine of $3,000 and imprisonment for a minimum of 5 and a maximum of 10 years for a second offense, and a maximum fine of $5,000 and imprisonment for a minimum of 10 and a maximum of 20 years for a third offense. Miss. Code Ann., § 6831–08 (Supp. 1964). See also note 167 infra.

[167] E.g., In Florida, possession or sale of barbiturates or stimulant drugs is punished by a maximum of 2 years for the first offense, not less than 2 nor more than 5 years for a second offense, and not less than 5 nor more than 10 years for succeeding offenses. Fla. Stat. Ann., § 404.15 (1960). In West Virginia possession or sale of dangerous drugs is punishable by a term of from 1 to 5 years for the first offense, and not less than 2 nor more than 10 years for subsequent offenses. W. Va. Code Ann., § 1385(32) (Supp. 1965). In North Carolina the sale of barbiturates or stimulating drugs is punishable by not less than 6 months nor more than 5 years imprisonment for a first offense, and not less than 1 nor more than 10 years for subsequent offenders. N.C. Gen. Stat., § 90–113.8 (Supp. 1965). In its recently enacted legislation prohibiting use and possession of LSD, lysergic acid, and DMT, Nevada has made second and subsequent offenses of either possession or use punishable by not less than 1 nor more than 10 years' imprisonment. Act of May 30, 1966, amending Nev. Rev. Stat., ch. 454.

[168] California provides for prison terms of not less than 1 nor more than 5 years for first offenses and not less than 2 nor more than 10 years for second offenses by persons who violate simple possession, possesion for sale, or sale provisions "by use of a minor as agent," or who solicit, encourage, induce, or intimidate, a minor "with intent that the minor shall violate any such provision, or who unlawfully" furnish, offer, or attempt "to furnish restricted dangerous drugs" to minors. Calif. Health and Safety Code, § 11913. In Washington State: "For any offense under the provisions of this chapter involving a sale to or other transaction with a minor, the offender shall be guilty of a felony and shall be fined not more than $50,000 and be imprisoned in the State penitentiary for not more than 20 years." Wash. Rev. Code Ann., § 69.40.070 (Supp. 1965). Mississippi law provides that "any person, firm, or corporation or anyone else who shall sell, bargain, or give away any barbiturate or stimulant * * * to any person eighteen (18) years of age or under * * * shall be sentenced to the penitentiary for a term of not less than 20 nor more than 30 years." Miss. Code Ann., § 6831–08 (Supp. 1964).

[169] Calif. Health and Safety Code, § 11911; Mass. Gen. Laws Ann., ch. 94, § 187E (Supp. 1965); N.H. Rev. Stat., § 318–42 (1965); N.C. Gen. Stat., § 90–113.2(5) (Supp. 1965); Ohio Rev. Code Ann., § 4729.51(c) (Page Supp. 1966); Va. Code Ann., § 54–441 (Supp. 1966).

Unlike the Federal amendments, State dangerous drug laws commonly punish possession even if it is for personal use if the drug was not obtained through legitimate channels.[172] The Model State Drug Abuse Control Act prohibits possession even if a drug was obtained by prescription or from a practitioner in the course of his professional practice if the drug is not kept in the immediate container in which it was delivered.[173] It was suggesed to the author by FDA officals that the provision of that act punishing possession even if it is for personal, household or animal use did not necessarily reflect the position of the FDA, but was inserted at the request of State law enforcement officials who believed that a simple possession crime was necessary to enable them to reach persons suspected of being traffickers but against whom sale or possession for the purpose of sale could not be proven. The act closely follows the Federal act in most other respects except that it contains provisions making criminal certain acts of misrepresentation, including the use of forged or altered prescriptions, connected with obtaining or attempting to obtain "depressant or stimulant drugs" [174] and that it provides for seizure and condemnation of conveyances used to transport or hold drugs with respect to which a prohibited act has occurred.[175] The act does not provide for registration or licensing of wholesalers or manufacturers.

The Virginia act and the pending legislation in New Jersey are similar, though not identical, to the Federal amendments, and it is to be expected that a good deal of new legislation in other states will be based on the Federal amendments.[176]

RECOMMENDATIONS DEALING WITH FEDERAL LAW

1. While the Food, Drug, and Cosmetic Act should not at the present require the keeping of any set form or forms of records to satisfy the recordkeeping requirements of section 511(d)(1), it should provide that records must (1) be segregated, or (2) be so kept that either the records themselves or the information required may be identified within a reasonable time after request, and reviewed or copied within a reasonable time.

2. The Food, Drug, and Cosmetic Act should require any person required to keep records pertaining to "depressant and stimulant drugs" under it and, in addition, contract and common carriers and practitioners to report the loss or theft of any "depressant or stimulant drug" to the Secretary of Health, Education, and Welfare promptly after discovery.

3. The Food, Drug, and Cosmetic Act should require that an initial inventory of a "depressant or stimulant drug" must be prepared by persons required to maintain records by section 511(d)(1) of the act whenever the Secretary by regulation designates a drug as a "depressant or stimulant drug" pursuant to section 201 of the act.

4. All the controls that the Drug Abuse Control Amendments of 1965 place on "depressant or stimulant drugs" should be extended to any precursor of a "depressant or stimulant drug" when the Secretary of Health, Education, and Welfare determines that (1) the "depressant or stimulant drug" of which it is a precursor has no significant nonexperimental medical use in the United States and (2) the precursor is being used in the manufacture of the "depressant or stimulant drug" in the United States otherwise than as authorized by the act.

5. The provision of the Drug Abuse Control Amendments of 1965 exempting practitioners from the recordkeeping requirements prescribed in the amendments should be retained at the present time.

6. The provision in the Drug Abuse Control Amendments of 1965 limiting the filling and refilling of prescriptions should not be changed.

7. The Food, Drug, and Cosmetic Act should in substance provide that nothing in section 511 of the act (21 U.S.C. § 360a),[177] other than subdivision (e) [21 U.S.C. § 360a(e)] (relating to the filling and refilling of prescriptions for "depressant or stimulant drugs") should be deemed in any way to interfere with the discretion of a practitioner to prescribe, administer or dispense any "depressant or stimulant drug" to a patient for the treatment of a disease or condition unless the practitioner treating the patient did not honestly believe that such prescription, administration or dispensation was advisable for the particular patient he treated. Such a provision should further state in substance that addiction or habitual use of a "depressant or stimulant drug" shall be deemed a "disease or condition" and that the prescription, administration or dispensation of a "depressant or stimulant drug" to an addict or habitual user of a "depressant or stimulant drug," even if solely for the alleviation of pain or suffering, shall be deemed a "treatment of a disease or condition" unless the practitioner treating the patient did not honestly believe that such prescription, administration or dispensation was advisable for the particular patient treated.

8. The provision of the Food, Drug, and Cosmetic Act prohibiting possession of "depressant or stimulant drugs" by unauthorized persons but excepting from the prohibition, possession "(1) for the personal use of the possessor or a member of his household, or (2) for administration to an animal owned by the possessor or a member of his household" should either be retained, or, preferably, a provision prohibiting unauthorized possession with a purpose to sell or otherwise dispose of a "depressant or stimulant drug" and exempting from this prohibition, possession (1) for personal use of a member of the possessor's household, or (2) for administration to an animal owned by the possessor or a member of his household should be adopted. Simple possession or use should not be punishable.

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[170] Ohio Rev. Code Ann., § 4729.51(c) (Page Supp. 1966).

[171] N.C. Gen. Stat., § 90–113.2(5) (Supp. 1965).

[172] Only Alaska, New Hampshire, Utah, and Vermont do not punish possession of illegitimately obtained dangerous drugs. The situation in Ohio is discussed in the text.

[173] Model State Drug Abuse Control Act, § 7(c).

[174] Id., § 7(d).

[175] Id., § 5(a)(6).

[176] The recent South Carolina legislation is also somewhat similar to the 1965 Federal amendments, but its parentage in the Model State Barbiturate Act is more evident.

[177] The controls which the Drug Abuse Control Amendments of 1965 place on depressant and stimulant drugs (other than the registration requirement for manufacturers and wholesalers) are contained in § 511 of the Food, Drug, and Cosmetic Act (21 U.S.C., § 360a).

However, Congress should enact legislation making the second numbered exception inapplicable to any controlled drug which the Secretary of Health, Education, and Welfare designates as having no significant nonexperimental medical use in the United States.

Congress should also enact legislation providing, in effect, that nothing in the Food, Drug, and Cosmetic Act should be deemed to interfere with any right protected by that clause of the first amendment to the United States Constitution which guarantees the free exercise of religion.

9. The Food, Drug, and Cosmetic Act should be amended to make unauthorized manufacture of a "depressant or stimulant drug" a criminal offense only when it is committed with a purpose to sell or otherwise dispose of such a drug. When it is not committed with such a purpose it may appropriately be a civil violation.

10. The Food, Drug, and Cosmetic Act should prohibit any person from obtaining or attempting to obtain a "depressant or stimulant drug" with a purpose to sell or otherwise dispose of the drug sought or obtained, by knowing misrepresentation, deception or subterfuge, from any person or firm that he believes is a manufacturer or wholesaler of such a drug or from any person whom he believes is an employee of such a manufacturer or wholesaler, and who in fact is a manufacturer or wholesaler of a controlled drug registered as such under the act or an employee of such a registered manufacturer or wholesaler.

11. (*a*) There should be no strict liability for criminal offenses under the Food, Drug, and Cosmetic Act relating to "depressant or stimulant drugs". If strict liability is desired, a civil violation punishable by fine, forfeiture, or other civil sanction should be considered.

(*b*) The basis of liability for unaggravated offenses under the Food, Drug, and Cosmetic Act relating to "depressant or stimulant drugs" should be negligence. Normal rules of justification should apply to such offenses. They should be misdemeanors punishable at the very most by a maximum of 1 year's imprisonment and a $1,000 fine.

(*c*) (1) "Depressant and stimulant drug" offenses under the Food, Drug, and Cosmetic Act which relate to failure to register; failure to prepare, obtain or keep proper records; refusal to permit access to or copying of records; and refusal to permit entry or inspection should be felonies punishable by a maximum of 3 years imprisonment and a $10,000 fine, if committed with an awareness that the failure or refusal is unlawful and with

(i) a purpose to manufacture or dispose or to further the manufacture or disposition of a "depressant or stimulant drug" otherwise than as authorized by the act and with an awareness of the unlawfulness of the manufacture or disposition intended or to be furthered, or (ii) an awareness that the failure or refusal will further the manufacture or disposition of a "depressant or stimulant drug" otherwise than as authorized by the act and with an awareness of the unlawfulness of the manufacture or disposition to be furthered. Normal rules of justification should apply to these offenses.

(2) Unauthorized manufacture with a purpose to sell or otherwise dispose, unauthorized possession with a purpose to sell or otherwise dispose, unauthorized sale or other disposition, and the filling or refilling of a prescription in violation of the prescription limitations imposed by the amendments should be felonies punishable by a maximum of 3 years' imprisonment and a $10,000 fine if committed knowingly. Normal rules of justification should apply to these offenses.

(*d*) The Food, Drug, and Cosmetic Act should be amended to give the trial judge authority after a verdict or finding of guilt of a felony to reduce the grade of the offense to a misdemeanor in all prosecutions for felonies relating to "depressant or stimulant drugs" (including the Federal misrepresentation and deception offense proposed herein and the existing offense "with intent to defraud or mislead"), if the defendant's conduct did not involve or was not directed to commercial distribution.

(*e*) The Federal misrepresentation and deception offense proposed herein should be a felony punishable by a maximum of 3 years' imprisonment and a $10,000 fine.

(*f*) The Food, Drug, and Cosmetic Act should not prescribe any enhanced penalty for sales to minors. The statutory maximum penalty for such sales should be the same as for other sales.

(*g*) The Food, Drug, and Cosmetic Act should not prescribe any enhanced penalty for subsequent "depressant or stimulant drug" offenses. The statutory maximum penalty for first offenses should apply to subsequent offenses also.

(*h*) The Food, Drug, and Cosmetic Act should be amended to deal with problems of cumulation of penalties and multiple convictions for "depressant or stimulant drug" offenses in the following manner:

(1) Cumulation of penalties for "depressant or stimulant drug" offenses, whether imposed after one trial or after separate trials, should generally be prohibited;

(2) Cumulation limited to a maximum term of 5 or 6 years and a maximum fine of $20,000 when one of the charges involved is a "depressant or stimulant drug" felony and a maximum term of 2 years and a maximum fine of $2,000 when no felony is involved should be permitted, in the discretion of the trial judge, when at least one of the offenses of which the defendant is convicted is committed after he has been charged with another "depressant or stimulant drug" offense and before sentence for that prior offense is imposed;

(3) The act should permit the entry of only one judgment of conviction when the defendant is charged solely with multiple "depressant or stimulant drug" offenses relating only to a single distribution, but when one of these offenses is a deception offense (as proposed herein) the act should permit the entry of a judgment of conviction for that offense as well as the entry of a judgment of conviction for one other "depressant or stimulant drug" offense related to the same distribution. However, cumulation of penalties for the deception offense and the other offense should be prohibited even if the Commission rejects a general bar on cumulation.

(*i*) Neither mandatory minimum penalties, nor restrictions on probation, suspended sentence, young adult treatment nor parole should be introduced for offenses relating to "depressant or stimulant drugs."

12. Congress should not enact any legislation dealing with smuggling of "depressant or stimulant drugs."

RECOMMENDATIONS DEALING WITH STATE LAW

It is further recommended that a model State act in large part uniform with and paralleling the Federal act be prepared for adoption by the States. Such an act would follow the basic pattern outlined below:

1. *Definition of Controlled Drugs.* The definition of controlled drugs should follow the Federal amendments verbatim and a federal administrative determination that a drug is a "depressant or stimulant drug" within the meaning of the Federal amendments should automatically make a drug a "depressant or stimulant drug" within the meaning of the State act. Similarly, drugs exempted from the Federal act should automatically be exempted by the State act.

It is suggested that those States desiring to give appropriate State authorities power to deal with problems which are peculiarly local should enact a further provision authorizing them to designate a drug as a "depressant or stimulant drug" on the basis of actual abuse within the State.

2. *Precursors.* If the recommendations for Federal control of precursors made herein are adopted, a model State act should upon a determination by the Secretary of Health, Education, and Welfare that a precursor of a "depressant or stimulant drug" is to be controlled under the Federal act automatically subject that precursor to the same controls that it places on "depressant and stimulant drugs."

States desiring to meet local problems may enact a further provision conferring upon an appropriate State agency authority to subject a precursor to the controls of the act when it determines that (1) the "depressant or stimulant drug" of which it is a precursor has no significant nonexperimental medical use in the United States and (2) the precursor is being used in the manufacture of the "depressant or stimulant drug" within the State otherwise than as authorized by the act.

Even if the Federal act is not amended to provide for controls on precursors, a model State act should give appropriate State authorities power to control precursors on the same basis on which it has been recommended the Federal Government should control them.

3. *Registrations and Listings.* (*a*) The act should require every person or firm owning or operating any establishment engaged in the manufacture of a "depressant or stimulant drug" within the State and every person or firm which is a wholesaler of such a drug which has an establishment or a place of business within the State to register annually with the State enforcement agency its name, all places of business within the State, and all its establishments within the State. The information required would be the same as required under Federal law and regulations. "Manufacture" and "wholesaling" should be defined as they are defined under the Federal act.[178] The registration requirement would be fulfilled by forwarding to the State enforcement agency a copy of the registrant's Federal registration.

(*b*) The act should also require the registration of warehouses within the State where "depressant or stimulant drugs" are kept. Similar information would be required. However, as in the case of manufacturers and wholesalers, if the warehouse is registered as a manufacturing or wholesaling establishment under the Federal act the requirement would be fulfilled by forwarding a copy of its Federal registration to the State enforcement agency.

(*c*) In addition, State agencies which license or register pharmacies and pharmacists, practitioners of the various healing arts, and hospitals, clinics, and public health agencies would be required to furnish the enforcement agency with a list of the names and locations of their registrants or licensees and, at intervals specified in the act to furnish the enforcement agency with revised lists. In the event any of the foregoing institutions or persons are not required by State law to register or obtain a license from any State agency it or he would be required to register annually with the enforcement agency. The registration would contain the name and address or location of the person or institution and the capacity in which he or it is registering (e.g., pharmacist or hospital).

Any hospital, clinic, or public health agency which is not required to register with or obtain a license to operate from any State agency but which operates under the supervision of a State agency would not be required to register with the enforcement agency, but the supervising agency would be required to provide the enforcement agency with a list of the names and locations of the hospitals, clinics, and public health agencies under its authority, and at intervals specified in the act to furnish the enforcement agency with revised lists.

(*d*) Persons and institutions that use "depressant or stimulant drugs" in research, teaching, or chemical analysis, including laboratories, research and educational institutions would be required to register annually with the enforcement agency. The registration would contain the name and address or location of the registrant and, if it is different, the name of the person in charge of the research, teaching or analysis; a statement that the registrant possesses "depressant and stimulant drugs"; and the location of the place where such drugs are kept.

(*e*) The act should require the enforcement agency to compile at specified intervals a register or list of persons or institutions who have registered with it either directly or by forwarding a copy of their registrations under the Federal act and of persons or institutions whose names and locations have been forwarded to it on lists prepared by State agencies. The act should also require the enforcement agency to make both this register or list and the registrations and lists upon which it is based available for public examination and inspection at reasonable times.

4. *Manufacture; sales and other dispositions; possession.* The act should follow the Federal act in pro-

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[178] While it is believed that the definition of "wholesale" under the Federal act is sufficiently broad that a wholesaler of controlled drugs who does not possess any controlled drugs within the State but who does have a place of business within the State would have an establishment within the State under the proposed model legislation, it would be desirable to specifically refer to places of business as well as to establishments.

hibiting manufacture, sales and other dispositions, and possession of controlled drugs, except by authorized persons for authorized purposes. The persons and purposes should be those enumerated in the Federal act as modified by the recommendations made herein for changes in Federal law. In addition, care should be taken to provide that out-of-State manufacturers and wholesalers who are registered under the Federal act and their employees acting in the course of their employment may sell and possess controlled drugs within the State even though they are not required to register under the State law, and that out-of-State practitioners may possess and, in emergencies, dispense or administer such drugs within the State for the immediate needs of patients.

Violations of prohibitions on manufacture, disposition, and possession should, subject to the recommendations herein with reference to culpability, be criminal offenses. In States where the legislation will be in the form of amendments to food, drug, and cosmetic acts modeled after the Federal act, violations of these prohibitions should be deemed prohibited acts.

It is recommended either that the provision of the Federal act which exempts from the prohibition on unauthorized possession, possession "(1) for the personal use [of the possessor] or a member of his household, or (2) for administration to an animal owned by him or a member of his household" and which puts the burden of proving that the possession was not for any of the purposes mentioned on the prosecution, or, preferably, a prohibition on unauthorized possession with a purpose to sell or otherwise dispose of a "depressant or stimulant drug," but exempting possession (1) for the personal use of a member of the possessor's household, or (2) for administration to an animal owned by the possessor or a member of his household, should be included in any State legislation. State law should not prohibit simple possession or use.

If Federal legislation is enacted making the second numbered exception to the possession provision inapplicable to any controlled drug which the Secretary of Health, Education, and Welfare designates as having no significant medical use in the United States other than experimental use, a model State act should provide that the parallel exception in it would automatically be inapplicable to a drug so designated by the Secretary of Health, Education, and Welfare.

A model State act should also contain a provision to the effect that nothing in it should be deemed to interfere with any right protected by that provision of the State constitution which in substance guarantees the free exercise of religion or with any right protected by the free exercise clause of the first amendment to the United States Constitution.

It is also recommended that unauthorized manufacture of a controlled drug should not be the subject of a criminal prohibition under a model act unless it is committed with a purpose to sell or otherwise dispose of such a drug. When it is not committed with such a purpose it may appropriately be a civil violation.

5. *Misrepresentation and Deception.* The act should prohibit such conduct as attempts to obtain and obtaining any controlled drug: (1) by knowing misrepresentation, deception, or subterfuge (*a*) from any person or firm (i) that the actor believes uses such a drug in research, teaching or chemical analysis or from any person whom he believes is an employee of such a person or firm, and (ii) who in fact is authorized by law to dispose of such a drug or is an employee of a person or firm authorized by law to dispose of such a drug, or (*b*) from any person or firm that (i) the actor believes is a manufacturer or wholesaler of such a drug, a warehouse, a contract or common carrier, a pharmacist or pharmacy, a practitioner, or a hospital, clinic or public health agency, or from any person whom he believes is an employee of any of the foregoing, and (ii) who in fact is authorized by law to dispose of such a drug or is an employee of a person or firm authorized by law to dispose of such a drug; (2) by use of a knowingly forged or altered prescription; (3) by use of a knowingly false name or address on a prescription.

6. *Other Prohibited Acts.* It is recommended that as under the Federal law failure to register, failure to prepare or obtain, or to keep complete and accurate required records, refusal to permit access to or copying of records as required by the act, refusal to permit authorized entry or inspection and the filling and refilling of prescriptions except as athorized by the act should, subject to the recommendations herein with reference to culpability, constitute criminal offenses. These offenses should be in the form of prohibited acts in States where provisions of the model act would be enacted in the form of amendments to a food and drug act based on the same format as the Federal Act.

7. *Basis of Liability, Grading and Penalties.* (*a*) It is recommended that basis of liability, grading, and penalties in a model State act be treated in the same manner as they would be treated under the recommendations made for Federal law. There should be no strict liability for criminal offenses. The basis of liability for misdemeanors should be negligence. Aggravated offenses like those recommended for Federal law should be incorporated in a model State act. State trial judges should be given the same authority to reduce the grade of an offense as would Federal judges. There should be no special statutory treatment of sales to minors or subsequent offenses. Problems of cumulation of penalties and multiple convictions should be treated in the manner proposed for Federal law.

(*b*) It is suggested that State offenses which correspond to Federal offenses should carry the same penalties as do the Federal offenses.

(*c*) It is recommended that the misrepresentation and deception offenses proposed for a model State act should be misdemeanors punishable by a maximum term of imprisonment that is at most no longer than 1 year and by a fine. It is recommended that if any of these offenses are committed with a purpose to sell or otherwise dispose of the drug sought or obtained, it should be a felony.

8. *Discretion of Practitioners.* The act should contain a provision guaranteeing the discretion of practitioners like that recommended for inclusion in the Federal act.

9. *Recordkeeping and Inspection.* A model State act should contain recordkeeping and retention provisions, provisions for an initial inventory, and provisions for inspection by agents of the State enforcement agency like the Federal provisions. It should also contain provisions for better availability of records, reporting of theft or loss and for initial inventories of newly designated drugs like those recommended for inclusion in Federal law. At the present time, practioners should be exempted from recordkeeping provisions to the same extent as they are under the Federal law.

If the Federal act is amended—as proposed—to require better availability of records or if neither Federal nor the State act adopt such a requirement, the model State act should provide that records and initial inventories prepared and kept in compliance with the recordkeeping requirements of the Federal act and regulations under it will be deemed adequate if they are made available, upon request, to the State enforcement agency.

10. *Prescription Limitations.* State legislation should contain the same restrictions on filling and refilling prescriptions as are contained in the Federal law. It is not recommended that State legislation place additional restrictions on filling or refilling prescriptions. It is believed that any restrictions on oral prescriptions in addition to those contained in the Federal law should be a matter for legislation in different States to meet local conditions.

11. *Injunctions.* A model act should give State enforcement agencies the power to seek, and State courts to issue, preliminary restraining orders, and temporary and final injunctions to restrain violations of the act, regardless of whether or not an adequate remedy at law exists.

12. *Other Provisions.* A model act should contain provisions for seizure and condemnation similar to Federal provisions and should permit the State enforcement agency to institute condemnation proceedings. The act should give authorized agents of State law enforcement agencies authority comparable to that given to FDA agents to make seizures, serve process in condemnation proceedings, make arrests, and carry firearms. It should also give the enforcement agency the authority to make rules and regulations under it.

13. *Enforcement Authority.* The proper State enforcement agency should be a matter for decision by each State.

14. *Relationship of Recommended Changes in Federal Law to State Law.* It is recommended that changes in Federal law proposed in this report also be incorporated in a model State act except where a difference is otherwise noted.

COMMENTS

Extensive Federal regulation of dangerous drugs has been in effect for a short time only. The Drug Abuse Control amendments became effective only on February 1, 1966. Consequently, it is difficult to make recommendations for changes in that legislation at this time. A number of matters which the author has considered as possible changes but has not recommended may be proven necessary at some time in the future. In its report on the 1965 Federal amendments the House Committee on Interstate and Foreign Commerce recognized that the 1965 amendments were not necessarily the final word.

> One approach which the committee considered is the approach used in the laws relating to hard narcotics under which extremely rigid controls are placed on raw materials and upon the manufacture and distribution of all narcotics. A special order form is required for all purchases, and strict accountability is imposed upon all persons in the chain of distribution.
>
> The committee felt that imposition of rigid controls of this type is not warranted at the present time, at least until the milder form of regulation contained in this legislation has been tried. Of course, if the problem continues to be a serious one, other approaches will be required in the future.[179]

While this report recommends some changes in the Federal scheme of regulation and offenses, these changes do not depart from the basic scheme of registration, inspection, and inventory records. Whether a stricter system of regulation involving such requirements as periodic inventories or formal running inventories or a narcotic-like system of transfers and returns under which official order forms would have to be filed with the FDA may prove necessary at some future date, cannot be said at this time. The FDA must develop experience under the existing law, and it is recommended that the effectiveness of that law be subjected to continuing review.

It is recommended that State legislation should be based essentially on the Federal legislation (as modified by the proposals herein) and that State laws be essentially uniform. While the 1965 Federal amendments apply to both intrastate and interstate activities relating to dangerous drugs, it is not recommended that Congress preempt the regulation of such drugs. The amendments themselves expressly disclaim any such desire except in cases of "direct and positive" conflict between Federal and State law so that the Federal and State provisions "cannot be reconciled or consistently stand together." [180] Further, the amendments permit the States to place controls on production, distribution, and possession which are more restrictive than those of the Federal law.[181] Preemption would be undesirable, because the States have traditionally regulated drugs, the drug industry and the healing arts professions under the police power,[182] and it should appear that a continued State role in regulation would be detrimental to control of the dangerous drug problem before Federal law should occupy the field.

Affirmatively, State legislation based esesentially on Federal legislation may—especially if there is active State enforcement and cooperation between State enforcement agencies and the FDA—make for more effective regulation. This suggests both that State legislation is desirable and that it be essentially similar to the Federal legislation. The latter conclusion is also supported by the fact that different Federal and State requirements, particularly with respect to recordkeeping, would put additional burdens on the regulated. Such burdens—which sometimes may be justifiable—would be compounded if interstate businesses were subjected to differing requirements in different States and to still different Federal requirements.

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[179] House Report at 3 [emphasis supplied]. See also the President's Advisory Commission on Narcotic and Drug Abuse, final report 44 (1963). The Commission in recommending legislation like the 1965 Federal legislation and for the present rejecting a scheme of regulation like that contained in the narcotics laws stated "The use of special registration forms for dangerous drug transfers may eventually prove to be a necessity to achieve adequate control over the distribution of these drugs. However, experience with regulation based on the keeping of inventory records should be developed first."

[180] Public Law 89–74, § 10(b), 79 Stat. 226, 235, 89th Cong., 1st sess. (July 15, 1965).

[181] Id., § 10(a).

[182] 1965 interim report of the Narcotic Drug Study Commission of the New Jersey Legislature 81 (1966) (hereinafter "1965 N.J. Report").

While it is recognized that special problems in particular States may justify these burdens and that unless Congress preempts the field individual States will respond to pressing internal problems as they think necessary. It is believed, not only that State legislation should be based essentially on the 1965 Federal amendments (as modified by the proposals herein) but also that State legislation should be essentially uniform.[183] These recommendations would seem to parallel other thinking on the subject, because Virginia [184] has recently enacted legislation similar to the Federal legislation, New Jersey is in the process of doing so,[185] and the recently prepared Model State Drug Abuse Control Act is quite similar to the 1965 Federal amendments.

COMMENTS TO FEDERAL RECOMMENDATIONS

RECORD KEEPING, REPORTING, AND INVENTORY CHANGES

The 1965 amendments regulate production, distribution, and possession of controlled drugs by registration, record keeping, inventory, and inspection requirements in addition to making unauthorized production, disposition, and possession criminal offenses.

Before discussing recommendations relating to changes in these requirements under Federal law, the purposes that they are designed to serve should be indicated. They are several. First, the FDA hopes by them to gain information regarding the extent of the dangerous drug problem in the United States and where in the chain of distribution diversions occur.[186] Second, it is hoped that they will facilitate the detection of violations and furnish leads to violations. Third, it is hoped that they will deter diversions and induce efforts by individuals to insure that their businesses are conducted so that persons other than those responsible for their management (e.g., employees, purchasers, would-be thieves) cannot divert drugs from the record keeper without his knowledge.

The likely deterrent effects of the requirements deserve examination. Certain persons will be induced to comply by criminal prohibitions on unauthorized production, distribution, and possession alone. To the extent that the regulatory requirements of the amendments increase the likelihood of detecting persons committing these offenses, certain persons will be induced to comply with the basic prohibitions of the law who would not be induced merely by the creation of these offenses. A person who may have been distributing controlled drugs at large and who might have continued to do so if distribution were prohibited, but there were no such regulatory provisions may cease doing so when he must keep records which are open to inspection. He may either confine his activities to legitimate ones, or in some cases, go out of business. Other persons may continue illicit distribution despite such requirements. They may believe that they can avoid detection by failing to keep records, by hiding supplies of controlled drugs from inspection or by misstating their records. However, where, as in most regulatory schemes, violations of the regulatory requirements are themselves offenses, such persons leave themselves open to prosecution for violation of these requirements if they are detected.

Requiring all persons in a chain of distribution to keep interrelated records of receipt and distribution makes it easier to facilitate detection of one person in the chain by a comparison of the records of his suppliers and of purchasers from him with his records. Such requirements probably also induce some persons to observe the law who otherwise would not. Furthermore, registration not only gives the regulatory agency some information as to the extent of the traffic in controlled substances and as to what persons or organizations are engaged in their manufacture and distribution, but the public availability of information as to particular registrations may enable persons endeavoring to comply with the law to discover persons who would use them unwittingly to make illegitimate sales, or, perhaps also, unwittingly to make purchases from illegitimate sources. Of course, a requirement that all persons in a chain of distribution must be keep records will probably not deter violations when the entire scheme of distribution is illicit. In addition, FDA officials informed the author that inventory and recordkeeping requirements pertaining to manufacturing have their limitations, because there is almost never a 100 percent yield in the processing of chemicals. One almost never gets all the finished product that he theoretically should under the process and with the quantity of the initial material employed. There is room for diversion within normal variations in yield, and within certain limits, "losses" do not necessarily prove diversion.

Thus, regulatory requirements such as those contained in the 1965 amendments are not complete insurance against diversion.

As Congressman Harris of Arkansas, the Chairman of the House Commerce Committee, stated in the House debate H.R. 2:[187]

> The bill will not eliminate all traffic in dangerous drugs. There will still be some unscrupulous individuals and firms that will deliberately try to evade the law. But the bill will make it possible to detect points of major diversion in a way that is not possible today.

Nevertheless, it may be assumed that the provisions will have some deterrent effect and also will enable the FDA to detect and furnish leads to violations and to gain information regarding the extent of the dangerous drug problem and of patterns of distribution of these drugs.

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[183] See 1965 N.J. Report at 80–82.

[184] Va. Code Ann., §§ 54–446.3—.13 (Supp. 1966).

[185] N.J. Assembly No. 548 (introduced Mar. 14, 1966).

[186] Statement of Representative Harris of Arkansas, 111 Congressional Record 4577, col. 3 (House) (daily ed., Mar. 10, 1965).

[187] 111 Congressional Record 4577, col. 3, 89th Cong., 1st sess. (daily ed., Mar. 10, 1965).

The deterrent effect presumably will be greatest on diversions from legitimate channels, and especially diversions at the higher levels of distribution. Both FDA officials and representatives of a large pharmaceutical manufacturer with whom the author spoke during the course of this study expressed the opinion that the Federal amendments would probably stop most large scale diversions from legitimate channels.[188] Requirements like periodic inventories or a narcotic-like system of regulation involving the reporting of all transfers to the FDA would have a somewhat greater deterrent effect; the tighter you turn the screws, the more diversions you may expect to reach. However, there is no way of knowing how much greater that effect might be or, at the present time, that the existing law will not reduce diversions sufficiently to make resort to any of such devices unnecessary. Experience must be gained under the present law. Furthermore, it should be emphasized that even the strictest system of regulation will not totally eliminate diversions or deter all violations.

Unlike narcotics many of the dangerous drugs are widely used in the treatment of disease. It is also conceivable that a narcotic-like system of regulation may hamper legitimate use of "depressant and stimulant drugs" in the healing arts. The President's Advisory Commission on Narcotic and Drug Abuse was of this view: [189]

> It should always be recognized that such dangerous drugs are medically valuable. They are prescribed or dispensed by physicians in millions of cases every year. The Commission believes that any new regulation covering their manufacture, sale, and distribution should not parallel the form of regulation under existing Federal narcotics laws which require all narcotic drug transfers to be registered with the Federal Government on Treasury forms. The stringent controls of the narcotics laws might seriously hamper the legitimate medical use of these other drugs.

While the hallucinogens generally have no nonexperimental medical uses in the United States at the present time, it is believed that in the main they should be regulated as are the commonly used "medically depressant or stimulant drugs." It is also believed that marihuana should be regulated in the same as are other hallucinogens, but regulation of marihuana will be discussed separately.

What has no medical use today may be valuable tomorrow. Even now LSD is being used experimentally in the treatment of chronic alcoholism and other personality disorders.[190] A direct prohibition on nonexperimental use would not meet the situation which would obtain if and when particular hallucinogens are found to have significant medical use. The regulatory scheme should be sufficiently adaptable to meet this situation. It is also possible that a direct prohibition on nonexperimental use of hallucinogens might set forth an attitude which would discourage research efforts. Research in LSD and other investigational new drugs can be supervised under the provisions of the Food, Drug, and Cosmetic Act relating to investigational new drugs and regulations under it.[191]

Since the hallucinogens available in the United States are largely manufactured or grown illicitly or smuggled into the United States from abroad, it is questionable whether a narcotic-like system of regulation would be more effective than the regulatory scheme of the 1965 amendments in controlling traffic in them. Moreover, such a system of regulation might also discourage research into medical use or discourage widespread medical use if and when some such use should become justifiable.

It should be recognized that more stringent controls on "depressant or stimulant drugs" may place burdens on the regulated. If such controls are necessary these burdens are unavoidable. On the other hand, there may be situations where although a regulatory requirement may be helpful, what one can hope to gain from it does not warrant the imposition of such a burden. It is believed that at the present time periodic inventories may present such a situation.[192]

On the other hand, future experience under existing law may prove that more restrictive regulation is necessary despite any inconvenience it may cause to businessmen. It is the view of the author that the recommendations made herein for a requirement of better availability of required records and for prompt reporting of thefts or losses of controlled drugs, as well as for controls on precursors, are sufficiently desirable that they should be incorporated into the law despite any inconvenience they may cause.

Availability of Records

The recordkeeping provisions of the 1965 amendments specifically provide that "No separate records, nor set form or forms for any of the foregoing records, shall be required as long as records containing the required information are available."

The House and Senate reports on H.R. 2 both state that "The purpose of this provision is to insure that the ordinary business records kept by legitimate businessmen will be considered as adequate records for the purpose of this legislation." [193]

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[188] See also Pumpian, "The Role of the State Board of Pharmacy," 2 J. National District Attorney's Association 13, 14 (1966): "* * * it appears that the provisions of the Drug Abuse Control Amendments of 1965 are sufficient to prevent a large-scale illicit traffic in drugs * * *." Mr. Pumpian who is a lawyer and a pharmacist is Assistant to the Director of the Bureau of Drug Abuse Control of the FDA and was formerly secretary of the Wisconsin Board of Pharmacy.

[189] The President's Advisory Commission on Narcotic and Drug Abuse, final report 44 (1963). See also statement of Representative Minish of New Jersey, 111 Congressional Record 4579, col. 3 (House) (daily ed., Mar. 10, 1965).

[190] Hoffer, "D-Lysergic acid diethylamide (LSD): A Review of its present status," 6 Clinical Pharmacology and Therapeutics 183, 218–25 (1965); "The Drug Takers," 99 (Time Inc., 1965).

[191] LSD is a new drug as defined by the act. A new drug is, inter alia, a drug which "is not generally recognized * * * as safe and effective for use under the conditions prescribed, recommended or suggested in the labeling thereof * * *." § 201(p)(1), 21 U.S.C., § 321(p)(1). Sec. 505(a) of the act (21 U.S.C. § 355(a)) prohibits the introduction and delivery for introduction into interstate commerce of any new drug unless the Secretary of Health, Education, and Welfare has approved a new drug application for the drug. Violation of this provision is a prohibited act. Sec. 301(d), 21 U.S.C., § 331(d). No new drug application has been approved for LSD. Sec. 505(i), 21 U.S.C., § 355(i) provides that the Secretary "shall promulgate regulations for exempting from" restrictions on new drugs, "drugs intended solely for investigational use by experts qualified by scientific training and experience to investigate the safety and effectiveness of drugs." The investigational new drug regulations are contained in 21 CFR, § 130.3. In effect, LSD may be used in the United States only under investigational new drug approvals.

[192] The requirement of an annual or biennial inventory would be helpful to the FDA, not only for any possible deterrent effect it might have but because under the amendments records have to be kept for 3 years, and if the FDA cannot or does not inspect an establishment and examine its records during the first 3 years of the act, it will have no base point to use to get a complete picture of the establishment's operation from the time the amendments became effective until the time of inspection. While such a requirement would reduce the inspection burden on the FDA and enable the collection of more complete information on the operations of particular establishments and on trends with respect to dangerous drug production and distribution, and thus, on the extent of the drug problem in the United States, the FDA does not claim it is necessary for the detection of violations. Further, FDA officials have informed the author that representatives of retail pharmacists take the position that each inventory would put the pharmacist to considerable expense, because most pharmacists cannot undertake such an inventory in the ordinary course of business and would have to hire organizations specializing in inventories to do the job. In fact, the author has been informed that generally speaking it is not the large enterprise, whether it be manufacturer, wholesaler, or retail pharmacy, that suffers from increased regulatory requirements but the smaller one.

[193] House Report at 8; S. Rept. No. 337, p. 6, 89th Cong., 1st sess. (1965). See also 111 Congressional Record, p. 4296, col. 2 (Representative Harris of Arkansas), p. 4306, col. 2 (Representative Broyhill of Northern Virginia) (Mar. 9, 1965) (daily ed.) (House).

Both in testimony before the House Committee and in a letter to the Committee, the FDA pointed out the provision, merely requiring that records containing the required information "be available," "could, if literally construed, place an undue burden both on our inspectors and on establishments subject to inspection,"[194] because inspectors had in the past been faced with quantities of unorganized records which it took them an inordinate amount of time to work through.[195] Because of this the FDA suggested:[196]

> It would be preferable, we think, to express the congressional intent in this respect in legislative history rather than in the form of a rigid limitation in the bill, but if the provision is retained we suggest that it be clarified by inserting the words "readily and conveniently" or words of like import before "available." * * * This would make clear that the required records are not to be kept in such order and disarray as to prevent an expeditious inspection.

The bill, of course, was not amended as the FDA suggested.

It is recommended that while the act should not at the present time require the keeping of any set form or forms of records, it should provide that records must (1) be segregated or (2) be so kept that either the records themselves or the required information may be identified within a reasonable time after request, and reviewed or copied within a reasonable time.

In the case of most persons using a manual system of recordkeeping this requirement would usually result in segregated records. Of course, if a person having such a system can keep records without segregating them so that they may be identified in a reasonable time after request and reviewed or copied within a reasonable time, he would be permitted to do so. The alternative requirement that records must be so kept that required information can be identified within a reasonable time after request and reviewed or copied within a reasonable time is primarily directed to firms maintaining electronic systems.[197] These systems cannot produce the required information immediately upon request but can do so within a reasonable time after request.

Inspection of records is a primary means through which the FDA can pinpoint and trace diversions of drugs. Since the amendments do not require that any records or returns be sent to FDA, actual inspection of records is at the heart of the regulatory system. While segregation may cause some inconvenience to some businesses, it is believed that it is warranted by the crucial nature of the inspection in the regulatory scheme. The failure to maintain records which are not readily identifiable can create a totally unjustifiable demand on FDA manpower. This manpower is sorely needed for other inspections and other purposes. It is believed that from the point of view of those affected by it any inconvenience caused by the requirement would be preferable to a requirement that records or returns must be forwarded to the FDA.

Reports of Theft or Loss

It is recommended that all persons required by the 1965 amendments to keep records and, in addition, contract and common carriers and practitioners should be required to report theft or loss of "depressant or stimulant drugs" to the FDA promptly after discovery.

The report should include the kind and quantity of the drugs stolen or lost and the date of the loss or theft. It is also recommended that a similar requirement of a report to the State enforcement agency be included in a model State act.

Such a requirement is found in the New York Depressant and Stimulant Drug Control Act.[198] The New York act also requires prompt reporting of the destruction of controlled drugs.[199]

Reports of theft or loss to the FDA would seem highly desirable as they would promptly inform it that controlled drugs either probably or definitely are outside legitimate channels of distribution. Prompt reporting will enable the FDA to attempt to trace these diversions.

Even though close cooperation between the FDA and State enforcement agencies is anticipated, the matter is considered significant enough to warrant a corresponding requirement in State legislation that a prompt report be made to the State enforcement agency.

The reporting requirement should extend to practitioners. Information as to thefts or losses from practitioners should not be privileged even if it involves patients and even if information from practitioners pertaining to efforts by their patients to obtain controlled drugs unlawfully is otherwise privileged, as long as disclosure of the name of the patient is not required.[200]

Initial Inventory of Newly Designated Drugs

The Federal amendments, of course, require an initial inventory of all "depressant or stimulant drugs" on hand as of their effective date. However, they do not expressly require an initial inventory of drugs which are designated as "depressant or stimulant drugs" after the effective date of the amendments. Such a requirement would seem implicit in the first. An initial inventory serves no function for drugs which were designated before the amendments became effective or which are named in the act that it does not also serve for newly designated drugs. It would seem that the lack of express language relative to newly designated drugs was an oversight. The FDA by regulation required that an initial inventory of newly designated drugs be made and retained.[201] Further, the Model State Drug Abuse Control Act contains such a provision.[202] A provision explicitly requiring the making and retention of an initial inventory of such drugs should be added to the Federal act.

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[194] Letter from Wilbur J. Cohen, Assistant Secretary of Health, Education, and Welfare to the Chairman of the House Commerce Committee, dated Jan. 27, 1965, printed in House Report at 21, 22; testimony of Commissioner Larrick, Hearings at 27.

[195] During his testimony before the House Commerce Committee, Commissioner Larrick stated:

> For example, a firm which manufactures tens or even hundreds of different articles might have all of the required information on depressant or stimulant drugs contained in invoices which may be filed with invoice for all products the firm distributes. We ran into such a situation recently where we inspected the records of a small firm in New York, having an annual gross volume of only $250,000 in depressant and stimulant drugs. This was less than 10 percent of the firm's total gross volume. The records on depressant and stimulant drugs were not segregated from the records of other products. It took our inspectors 250 man-hours to check these records * * *. Ordinarily, manufacturers would prefer that our inspectors would not remain in their establishment 250 man-hours.

Hearings at 27.

[196] Letter from Secretary Cohen to Chairman Harris of Jan. 27, 1965, note 194 supra, printed in House Report at 22. See also testimony of Commissioner Larrick, hearings at 27.

[197] Regulations promulgated under the amendments provide:

> With regard to the records required by sec. 511(d)(1) of the act, the law states "no separate records not set form or forms for any of the foregoing records shall be required as long as records containing the required information are available." [At this point a footnote states: "The purpose of this provision as shown by reports of the congressional committees that considered the legislation is to insure that the ordinary business records kept by legitimate businessmen will be considered as adequate records."] Ordinary business records kept by legitimate businessmen are maintained so that inspection of the records is possible and practicable in a reasonable length of time. Among others, an automatic data processing system will be considered adequate providing the system is capable of separating and identifying all records containing the specific information required by sec. 511(d) of the act and the regulations contained in this part in a reasonable time, or provided the system itself is capable of producing such information in a reasonable time. Other recordkeeping systems that permit the records specified in sec. 511(d)(1) of the act to be identified and reviewed or copied in a reasonable time also will be regarded as adequate. To account for controlled drugs dispensed on prescription, either the usual consecutively numbered prescription file, or a separate prescription file, will be acceptable.

21 CFR, § 166.16(b)(3)(iv), Federal Register, Jan. 27, 1966, p. 1074, col. 1.

The regulations under the New York law require manufacturers to maintain depressant and stimulant drug records "in a separate file or in such a manner as will make them readily available for inspection * * *." N.Y. Regs., § 82.82(g).

[198] N.Y. Public Health Law, § 3388–7.

[199] Ibid.

[200] Both the Uniform Narcotic Drug Act and the New York Depressant and Stimulant Drug Control Act provide that information communicated to a practitioner in an effort unlawfully to procure a controlled drug or the administration of a controlled drug shall not be deemed a privileged communication. Uniform Narcotic Drug Act, § 17(2); N.Y. Public Health Law, § 3389–3.

PRECURSORS

Certain drugs which may not have characteristics which enable them to be deemed as "depressant or stimulant drugs" under the 1965 Amendments may be capable of conversion into such "depressant or stimulant drugs" or may otherwise be used in the manufacture of such drugs. They may be used in the illicit manufacture of "depressant or stimulant drugs." Under existing law the manufacturer of the "depressant or stimulant drug" would, if he is not registered, commit a prohibited act in manufacturing it. Similarly, if he distributed or possessed for distribution he would be committing a prohibited act. However, under existing law the manufacturer or distributor of a precursor used in the manufacture of the "depressant or stimulant drug" could not be reached under the amendments if he did not distribute, possess for distribution, or manufacture the ultimate "depressant or stimulant drug" unless the precursor were itself a "depressant or stimulant drug" within the meaning of the amendment.[203] If the precursor were itself a "depressant or stimulant drug" or if precursors were to be controlled like "depressant and stimulant drugs," he could be charged with unauthorized manufacture, possession, or disposition, as the case might be, and in addition would be subject to the registration, inventory, recordkeeping and inspection provisions of the amendments. If he were subject to the amendments he might well refrain from manufacturing the precursor for distribution to unauthorized persons or from distributing it to such persons.[204] To the extent that he would, the supply of the precursor available to would-be unauthorized producers of the ultimate "depressant or stimulant drug" would decrease.

With some qualification, LSD may be an example. LSD may be produced by putting lysergic acid or lysergic acid amide through a series of chemical processes. Apparently, some of the LSD illicitly available in the United States and not smuggled in from abroad has been produced by illicit producers in this way. Under the present law, unless lysergic acid and lysergic acid amide were themselves "depressant or stimulant drugs" under the act, producers and distributors of these drugs who did not themselves manufacture or distribute LSD could not be subjected to the controls of the amendments.

Because it found that lysergic acid and lysergic acid amide have a depressant effect on the central nervous system, the FDA by regulation declared them to be "depressant or stimulant drugs" and brought them under the coverage of the amendments.[205] However, had the FDA been unable to make such a determination, it presumably could not have subjected them to the controls prescribed by the amendments. It is to meet such a problem that the instant recommendation is made.

Control of precursors presents difficult problems. Authority to place a precursor of any "depressant or stimulant drug" under control merely because it is a precursor or merely because there has been some small use of it in the illicit production of a "depressant or stimulant drug" could lead to unnecessary controls on large numbers of substances and on persons who produce or distribute precursors for legitimate purposes. In enacting the 1965 Drug Abuse Control Amendments, Congress was particularly sensitive to undue extensions in coverage. The House report on H.R. 2 stated: [206]

> While the bill would apply to all depressant or stimulant drugs, it would not apply to basic chemicals intended and used for nondrug purposes. For example, firms that ship or receive unsubstituted barbituric acid or other potentially depressant or stimulant drugs for industrial nondrug purposes would not be subject to the recordkeeping and other requirements of the bill.

Standards which would permit control of a precursor upon a finding that it is being used in the illicit production of a "depressant or stimulant drug" in significant amounts or in amounts sufficient to pose a hazard to the public health or safety might avoid undue extensions of coverage. But such standards are subject to objection also. First, they may be unduly ambiguous. Second, while it may be possible for the FDA to show some specific instances of illicit production of a "depressant or stimulant drug" involving a precursor, given the clandestine nature of illicit operations, such showings would be limited. Thus, the FDA might not be able to show enough specific instances to warrant a conclusion that the precursor was being used in significant amounts or in amounts sufficient to pose a hazard to the public health or safety. Moreover, to the extent that application of the latter standard might involve a comparison of illicit production involving use of precursors with total illicit production, again given the clandestine nature of illicit operations, it would appear that it would be impossible for the FDA to make the comparison.

There is probably no completely satisfactory solution to the problem. It is believed, however, that regulation of a precursor when the Secretary determines that (1) the "depressant or stimulant drug" of which it is a precursor has no significant nonexperimental medical use in the United States, and (2) the precursor is being used in the manufacture of the "depressant or stimulant drug" in the United States otherwise than as authorized by the act, affords a workable solution.

Controls over precursors are most significant in the case of "depressant or stimulant drugs" which have no or only limited use in the United States, because illicit production of such drugs is likely to be a more significant factor in their introduction to illicit channels of distribution than it is in the case of "depressant or stimulant drugs" having significant medical use.[207] Drugs having significant medical use are more likely to be introduced into illicit channels by way of diversions from legitimate sources than by way of illicit production. Even where there is illicit production of such drugs, diversions from legitimate sources presumably will be significant enough that controls over precursors will not be particularly significant in controlling the illicit traffic. Where, however, a drug has no significant medical use in the United States, it is more likely that controls over precursors will be significant in controlling the illicit traffic.

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[201] Federal Register, 21 CFR, § 166.16(a)(2), Mar. 19, 1966, p. 4680, col. 1.

[202] Model State Drug Abuse Control Act, § 7(e)(1).

[203] Of course, under some circumstances there may be liability for complicity (18 U.S.C., § 2) or conspiracy (18 U.S.C., § 371).

[204] It is not, of course, claimed that that extension of the controls of the amendments to precursors would totally eliminate manufacture for distribution to unauthorized persons or distributions to such persons. The limitations of inventory and recordkeeping requirements have already been discussed.

[205] Federal Register, 21 CFR 166.3, May 18, 1966, pp. 7245, col. 3 and 7246, col. 1 (proposed).

[206] House Report at 6. Identical language is found in the Senate report on the bill. S. Rep. No. 337, 89th Cong., 1st sess, p. 3 (1965).

The recommendation also requires a showing by the FDA of some actual use of the precursor in illicit production of the "depressant or stimulant drug." The purpose of this requirement is to insure that there is some need for control of the precursor.

PRACTITIONERS' EXEMPTION FROM RECORD-KEEPING REQUIREMENTS

It must be recognized that the exemption from the recordkeeping and inspection provisions of the Federal amendments of practitioners who do not regularly engage in dispensing "depressant or stimulant drugs" to patients for a fee leaves a gap in the regulatory scheme. Ideally, a system of interrelated recordkeeping should make every link in the chain of distribution accountable for drugs coming in and for drugs going out.

The exemption was justified in Congress on the ground that there had in the past been only a small number of drug violations by practitioners.[208] Although it should be noted that recordkeeping and inspection reuirements might uncover or furnish leads to violations that now are undiscovered, when the exemption is viewed in light of the known number of violations the gap in the regulatory scheme may be viewed as more apparent than real. In addition, elimination of the exemption would extend the recordkeeping requirements to large numbers of persons. In the House debate on H.R. 2 Congressman Jarman of Oklahoma, a member of the committee which reported on the bill, stated that there were 230,000 physicians, 84,000 dentists and 15,000 veterinarians in the United States.[209] For these reasons it is believed that the politically difficult task of repealing the exemption should not be attempted at this time. But if the number of violations by practitioners should show signs of increase, repeal of the exemption should be considered.

Existing State law on the subject is not uniform. The Model State Barbiturate Act requires recordkeeping of practitioners.[210] However, two jurisdictions which have based their legislation on the act have exempted practitioners from recordkeeping.[211] The Model State Drug Abuse Control Act,[212] the recent legislation in Virginia [213] and the proposed legislation in New Jersey [214] contain the exemption contained in the Federal amendments. On the other hand, the dangerous drug laws of over 20 States require some recordkeeping of practitioners.[215] The 1965 New York law, amended in 1966, is one of these.[216] In the interests of uniformity with the Federal act it is recommended that the exemption be included in a model State act. However, the large number of States which require some recordkeeping of practitioners suggests that particular States may not desire to include it.

PRESCRIPTION LIMITATIONS

It is recommended that the limitations on the life of prescriptions and on refilling prescriptions in the 1965 amendments should be retained. The amendments limit the life of a prescription for a "depressant or stimulant drug" to a maximum of 6 months from the date of issue and provide that no prescription for such a drug can be refilled more than five times or more than 6 months after it was issued. The prescriber may, however, renew the prescription after five refills or 6 months.[217]

These limitations were designed to eliminate open-ended prescriptions under which a person could continue to obtain a dangerous drug long after his medical need for it had ceased or without the benefit of medical judgment as to whether a medical need continued.[218] It was believed that open-ended prescriptions facilitated addicts and habitual users in obtaining drugs and may have provided an opportunity for some persons to become dependent.[219]

On the other hand, the Federal limitations do not necessarily prevent a person who without the knowledge of his physician is addicted or otherwise dependent from obtaining drugs. A person may, if a pharmacist will fill it, have a prescription refilled five times in a short period and then obtain another prescription either from the same or another physician. This abuse could be curbed somewhat by a requirement that a prescription must designate a minimum time which must elapse between refills.[220] Moreover, the amendments permit oral prescriptions and oral refills if they are promptly reduced to writing by the pharmacist. Oral prescription permit persons to impersonate physicians and obtain drugs without a practitioner's approval. A requirement that the practitioner must follow up an oral prescription by a confirming written prescription within a designated period, as exists in some States, might limit this practice somewhat. A requirement that a pharmacist must confirm an oral prescription by telephoning the physician might have more effect. Finally, the abuses of oral prescriptions are eliminated by prohibiting them.

It is not believed that the Federal limitations should be changed at this time. Limitation on prescriptions would seem to be a matter predominantly for State action, because it involves restrictions on both practitioner and pharmacist. Before any additional Federal restrictions are enacted it should appear that there is substantial abuse despite the existing Federal provision.

While limitations like those in the Federal law should be included in a model State act, it is not believed that a model State act should contain stricter limitations at this time. These should await a demonstrated need.

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[207] Such drugs may also be unlawfully imported into the United States. Commissioner Goddard of the FDA has stated that LSD is being unlawfully imported into the United States. New York Times, May 23, 1966, p. 31, cols. 7 and 8. See also Levin, "LSD in New York: a reporter's inside look," part 5, New York Post, June 10, 1966, p. 46.

[208] See note 78 supra.

[209] 111 Congressional Record 4304, col. 3, 89th Cong., 1st sess. (House) (daily ed. Mar. 9, 1965). Commissioner Larrick reported these same figures in his testimony before the House Commerce Committee. Hearings at 100.

[210] See note 149 supra.

[211] See note 150 supra.

[212] Model State Drug Abuse Control Act, § 7(e)(3).

[213] Va. Code Ann., § 54-446.5(c) (Supp. 1966).

[214] N.J. Assembly No. 548, § 2(g)(3) (introduced Mar. 14, 1966).

[215] See note 151 supra.

[216] See notes 110 and 151 supra.

[217] Food, Drug, and Cosmetic Act, § 511, 21 U.S.C. § 360a(e).

[218] House Report at 9-10, 111 Congressional Record 4299, col. 1, 89th Cong., 1st sess. (remarks of Representative Springer of Illinois) (House) (daily ed. Mar. 9, 1965); Testimony of Dr. John Griffith, Director, Oklahoma Mental Health Planning Committee, Hearings at 307-08, 310, 311.

[219] See the authorities cited in the preceding note.

[220] Recommended in Fort, "The problem of barbiturates in the United States of America," 16 Bulletin on Narcotics, No. 1, 17, 30 (January-March 1964).

It is recognized, however, that individual States with peculiarly difficult problems involving the abuse of prescriptions may desire stricter legislation. It is hoped that such legislation will not, except perhaps as a last resort, require all dangerous drug prescriptions to be in writing. Elimination of oral prescriptions may seriously hamper the practitioner in prescribing in an emergency. While a requirement that the pharmacist must telephone the physician to confirm the prescription would not end all possibilities of abuse incidental to oral prescriptions, it would seem preferable.

DISCRETION OF PRACTITIONERS

The purpose of this recommendation is to insure that medical discretion relating to the prescription, administration, and dispensation of controlled drugs is explicitly protected by the act.

The practitioner's discretion involves both discretion short of supplying maintenance doses to addicts or habitual users of "depressant or stimulant drugs" and discretion to prescribe, administer and dispense maintenance doses to addicts and habitual users. There is probably complete agreement that discretion which does not involve supplying maintenance doses to addicts or habitual users should be protected. Discretion to supply maintenance doses to addicts or habitual users, particularly when ultimate withdrawal is not contemplated, is more controversial.

While supplying maintenance doses of a narcotic to narcotic addict patients by physicians has been a subject of great controversy,[221] and while supplying maintenance doses of either a narcotic or a "depressant or stimulant drug" to all comers and without any determination based on the clinical picture presented by the particular patient is to be condemned, it is strongly believed that whether a particular addict or habitual user of a "depressant or stimulant drug" is to be maintained on a drug presents a medical question involving the clinical picture presented by the particular patient. The criminal law should not step in unless the practitioner has not made an honest judgment based on the clinical picture presented by the particular patient that maintenance is advisable for that patient; an individualized determination honestly made should not subject the practitioner to criminal liability. This recommendation is not designed to state a governmental policy that addicts or habitual users of "depressant or stimulant drugs" are to be maintained. Rather, it is designed to provide a framework in which whether a particular addict or habitual user is to be maintained can be decided as a question of professional medical judgment.

The author is not a physician and does not venture to guess when maintenance is medically warranted. It may be medically warranted only in a small number of cases or in a considerable number of cases.[222] Under what circumstances maintenance is warranted should be left to the medical profession rather than either to law enforcement agencies or, to the extent that it is possible to do so, to the courts.

While it is believed that guidelines as to the circumstances when maintenance is appropriate should appropriately be evolved by the medical professional rather than by law enforcement agencies and that the medical profession should be encouraged to evolve such guidelines, it is not believed that criminal liability should depend on the prevailing view in the medical profession at a given time. To make it so depend might discourage honestly held minority views that in the course of time might or might not prevail. If the particular practitioner's view suggests to members of his profession that he is incompetent it is believed that the appropriate remedy is action by State or professional disciplinary bodies rather than resort to the criminal law. Such action should, of course, also be taken against prescription peddlers and practitioners who do not act in good faith. While fear of disciplinary action may also discourage minority views, it is believed that this is unavoidable. Moreover, it should be recognized that even in a criminal prosecution based on the practitioner's subjective belief the trier of fact may actually infer lack of good faith from the fact that the practitioner's treatment was not viewed as medically justified by expert medical opinion. Of course, under such a test the trier of fact would be free to ignore that opinion if it in fact believed that the defendant actually believed his treatment was advisable for the particular patient.

It is believed that a statutory provision expressly protecting the discretion of practitioners is necessary, because there is some confusion as to what extent a practitioner may lawfully supply maintenance doses of narcotics to a narcotic addict patient,[223] and this confusion suggests the possibility that medical discretion relating

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[221] See, e.g., AMA Department of Mental Health, Narcotics Addiction: Official Actions of the American Medical Association, passim (1963) (hereinafter "AMA: Narcotics Addiction"). In addition, the extent to which a practitioner may lawfully use maintenance doses of a narcotic in the treatment of a narcotic addict patient is by no means clear. See note 223 infra.

[222] In the case of narcotics addiction the American Medical Association in a code of ethical medical practice has sanctioned the use of maintenance doses for addicts for prolonged periods in certain limited situations—chiefly those involving aged and infirm addicts who might not survive withdrawal and bona fide research activities. The AMA also sanctions the administration of substitute narcotics for a period of up to 2 weeks to relieve withdrawal symptoms pending the patient's admission to a hospital, and narcotics may be administered in a hospital to relieve withdrawal symptoms. Narcotics may also be given to patients with chronic painful diseases for prolonged periods. "The use of narcotic drugs in medical practice and the medical management of narcotic addicts: a statement of the American Medical Association's Council on Mental Health and the National Academy of Sciences—National Research Council" (June 1963), in AMA: Narcotics Addiction 51–61.

[223] A treasury regulation currently in force and reflecting the language of a question certified to the Supreme Court in a case decided in 1922 (*Webb* v. *United States*, 249 U.S. 96) provides:

> A prescription, in order to be effective in legalizing the possession of unstamped narcotic drugs and eliminating the use of order forms, must be issued for legitimate medical purposes * * *. An order purporting to be a prescription issued to an addict or habitual user of narcotics, not in the course of professional treatment but for the purpose of providing the user with narcotics sufficient to keep him comfortable by maintaining his customary use, is not a prescription within the meaning and intent of sec. 4705(c)(2), and the person filling such an order, as well as the person issuing it, shall be subject to the penalties provided for violations of the provisions of law relating to narcotic drugs. 26 CFR, § 151.392.

Language in later opinions suggests that this language and the language in the opinion on which it is based is too broad. The defendant in *Webb*, a physician, did "not" issue the prescription involved "after consideration of the applicant's individual case" but apparently sold prescriptions to all comers at 50 cents apiece. *Webb* v. *United States*, 249 U.S. at 98. During the period covered by the indictment he had apparently sold over 4,000 prescriptions, sometimes using fictitious names on them. Id., at 99.

The question certified in *Webb* was:

> If a practicing and registered physician issues an order for morphine to an habitual user thereof, the order not being issued by him in the course of professional treatment in the attempted cure of the habit, but being issued for the purpose of providing the user with morphine sufficient to keep him comfortable by maintaining his customary use, is such an order a physician's prescription under [a provision which excepted from the application of the Harrison Act dispositions by a dealer to a consumer under and in pursuance of a written prescription by a registered practitioner]? *Webb* v. *United States*, *supra*, 249 U.S. at 99.

The Supreme Court, four justices dissenting, answered:

> * * * to call such an order for the use of morphine a physician's prescription would be so plain a perversion of meaning that no discussion of the subject is required. Id., at 99–100.

This broad answer was qualified by the Supreme Court in a series of cases decided between 1922 and 1926.

First, in a dictum in *United States* v. *Behrman*, 258 U.S. 280 (1922), in which the Court actually upheld an indictment against a physician which did not allege bad faith, it stated that "it may be admitted that to prescribe a single dose or even a number of doses may not bring a physician within the penalties of the act * * *. Undoubtedly doses may be varied to suit different cases, as determined by the judgment of the physician." 258 U.S. at 288, 289.

In 1925 in *Linder* v. *United States*, 268 U.S. 5, in dismissing an indictment which did not charge bad faith and which did "not question * * * the wisdom or the propriety of the [physician's] action according to medical standards," (268 U.S. at 17), the Court stated "What constitutes *bona fide* medical practice

Footnote continued on following page.

to the prescription, administration, and dispensation of "depressant or stimulant drugs" could be limited by administrative regulation or judicial decision if it is not safeguarded by statute.

USE AND POSSESSION OFFENSES

There are a number of offenses which may be utilized to punish the user who improperly obtains drugs for his use. Provisions prohibiting obtaining of dangerous drugs by fraud or misrepresentation, as by forging or altering a prescription, will often reach the user. These provisions are directed at preserving the integrity of legitimate channels of distribution, but they are capable of being employed to reach the user solely for his use. While no information has been obtained to what extent vagrancy and disorderly persons offenses are used to reach the dangerous drug user solely on account of his use, their use against narcotics addicts and alcoholics suggests that they are capable of being similarly employed against dangerous drug users. Unauthorized use of dangerous drugs is itself a crime in a few States.[224]

The crime of use is, of course, directed against use, but it may also be at least in part directed and utilized against distribution. Thus, prosecution for use may be directed against the user's conduct in obtaining the drug he used. Also, since it is not always easy to prove whether a person is a seller, the police may assume or suspect that a user is a seller and charge him with use when they are really directing their activities to trafficking.

The most common user offense is possession of a drug not pursuant to a prescription or not dispensed by a practitioner in the course of his professional practice—i.e., simple possession. Almost all State laws dealing with dangerous drugs make simple possession an offense.[225] The 1965 Federal amendments, on the other hand, exempt from their prohibition on possession, possession for the personal use of the possessor or of a member of his household, or for administration to an animal owned by him or by a member of his household.

A simple possession offense, like a use offense, can be used to serve a number of purposes.

From either of two standpoints, it may be viewed as a trafficking offense. First, it may be seen as an offense directed against the possessor's conduct in obtaining the drug. Second, it may be seen as an offense preparatory to a sale or other distribution by the possessor,[226] and, so viewed, may be employed against persons whom law enforcement officials believe are distributors, whether or not they are in addition users. Law enforcement officers often claim that this is how they view the offense. They claim its existence makes law enforcement easier, because they do not have to have evidence of a sale (by making a "buy") to prove a case, and they do not have to prove possession of fairly large quantities or have other evidence which might throw light on the purpose of the possession as they must under the Federal possession offense or a possession with intent to distribute offense.[227]

Finally, simple possession may be viewed as punishing for use by reaching conduct preparatory to use. In fact, the user is most commonly charged with simple possession.

While many of the problems pertaining to the creation of possession and use offenses for the commonly used "medically depressant and stimulant drugs" such as amphetamines, barbiturates, and nonbarbiturate sedatives (including some of the so-called tranquilizers) pertain also to the creation of such offenses for hallucinogens such as LSD which have no nonexperimental medical uses in this country, it is believed that the problems are sufficiently different to warrant separate recommendations and separate discussion.

The recommendations herein are not based on the view that criminal treatment of use or simple possession is unconstitutional. It is recognized that policy and constitutional considerations may tend to merge. However, the recommendations are based on considerations of what is believed to be proper policy. While it is possible to argue that some of the reasoning in *Robinson* v. *California*[228] indicates that punishment for use or even simple possession is unconstitutional, the Supreme Court there specifically stated that possession may still be treated as a crime.[229] As to use, it was less clear.[230] Most States and lower Federal courts have narrowly read ***Robinson*** and have held that use may still be made criminal.[231] In the absence of a determination by the Supreme Court, the author for the purpose of this report assumes that at present use and possession are constitutionally punishable.

"Medically Depressant and Stimulant Drugs"

The "medically depressant and stimulant drugs" which are currently of concern because of their possible potential

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must be determined upon consideration of evidence and surrounding circumstances." Id., at 18 [emphasis by the Court]. It clarified its answer to the question certified in *Webb* by stating:

> The question specified no definite quantity of drugs, nor the time intended for their use. The narrated facts show, plainly enough, that physician and druggist conspired to sell large quantities of morphine to addicts under the guise of issuing and filling orders. The so-called prescriptions were issued without consideration of individual cases and for the quantities of the drugs which applicants desired for the continuation of customary use. The answer thus given must not be construed as forbidding every prescription for drugs, irrespective of quantity, when designed temporarily to alleviate an addict's pains, although it may have been issued in good faith and without design to defeat the revenues." Ibid.

It also clarified its refusal to dismiss the indictment in *Behrman*.

> This opinion related to definitely alleged facts and must be so understood. The enormous quantity of drugs ordered, considered in connection with the recipient's character, without explanation, seemed enough to show prohibited sales and to exclude the idea of *bona fide* professional action in the ordinary course. The opinion cannot be accepted as authority for holding that a physician, who acts *bona fide* and according to fair medical standards, may never give an addict moderate amounts of drugs for self-administration in order to relieve conditions incident to addiction. *Linder* v. *United States, supra*, 268 U.S. at 22 [emphasis by the Court].

The following year in a dictum in *Boyd* v. *United States*, 271 U.S. 104 (1926), the Court in commenting on a portion of a charge which might have been understood as meaning that "it never is admissible for a physician in treating an addict to give him a prescription for a greater quantity than is reasonably appropriate for a single dose or administration," commented "so understood the statement would be plainly in conflict with what this Court said in the *Linder Case*." 271 U.S. at 107.

For a detailed history of the development in the courts, see Joint Committee of the American Bar Association and the American Medical Association on Narcotic Drugs, Appendix A to Interim Report (1958), reprinted in Drug Addiction: Crime or Disease? 68–82 (1961).

[224] Md. Ann. Code, art. 43, § 313B(b) (Supp. 1966) ("use or consume"); Act of May 30, 1966, amending Nev. Rev. Stat., ch. 454 ("use or possess"); N.J. Rev. Stat. 2A: 170–177.8 (Supp. 1965) ("uses or is under the influence of"); Okla. Stat. Ann., title 63, § 469 (1961) ("use"). See also Me. Rev. Stat. Ann., ch. 22, § 2215 (Supp. 1965) ("found to be under the influence of").

[225] See note 100 supra. The pending New Jersey legislation contains a possession provision identical to the Federal provision but, in addition, continues the existing proscriptions on use and "simple" possession. N.J. Assembly No. 548, §§ 2(f), 5 (introduced Mar. 14, 1966). Identical penalties are prescribed for all these offenses.

[226] Proscriptions on acquisition or on obtaining a drug may themselves be seen as offenses preparatory to ultimate sale or distribution by the person acquiring or obtaining the drug. So viewed they reach conduct even more remote from ultimate distribution than does a simple possession offense.

[227] A number of law enforcement officers, judges, and prosecutors made this point to the author. See also Blum Report at 29; Testimony of Dr. John Griffith, Hearings at 316; Letter of Walter F. Anderson, Director, North Carolina State Bureau of Investigation, to the author (July 22, 1966); Letter of Dr. Rupert Salisbury, then Executive Secretary of the Ohio State Board of Pharmacy, to the author (Aug. 1, 1966).

[228] In Robinson, 370 U.S. 660 (1962), the Supreme Court held that the cruel and unusual punishment clause of the eighth amendment, made obligatory upon the States by the 14th amendment, barred a State from treating narcotics addiction as a crime. Its reasoning would bar making addiction to dangerous drugs a crime.

[229] "A State might impose criminal sanctions, for example, against the unauthorized manufacture, prescription, sale, purchase, or *possession* of narcotics within its borders." 370 U.S. at 664 (emphasis supplied).

[230] See the dissenting opinion of Mr. Justice White, 370 U.S. at 685, 688.

[231] See note, "Alcoholism, public intoxication and the law," 2 Colum. J. of Law and Soc. Prob. 109, n. 142 at 128 (1966).

for abuse are amphetamines, barbiturates, and nonbarbiturate sedatives (CNS depressants).

These drugs are all widely used in medical practice. While meaningful figures are not available,[232] they are also apparently widely used by persons on their own account either without medical authorization or in excess of such authorization. [233] A significant amount of this illicit use would appear to be in self-medication.[234]

Barbiturates and barbiturate-like CNS depressants apparently produce a similar dependence. Excessive use may lead to physical dependence.[235] The effects of this dependence are similar for both.[236] Withdrawal can be a more dangerous process than is withdrawal from the opiates. Delerium or convulsions are sometimes encountered.[237] Little is known about treatment of those dependent on these drugs. However, it is has been indicated that the prognosis for cure is poor, and the problems presented are very similar to those encountered in the treatment of opiate addicts.[238]

While we do not know the extent of the problem, there are apparently more persons dependent on barbiturates than on opiates.[239] In addition, there is an unknown but apparently large number of nondependent persons who on occasion use barbiturates outside of medical channels or in excess of medical authorization.

In his study for the Commission, Professor Blum reports that barbiturate overdose is one of the chief means of suicide in the United States,[240] and that death by accidental overdose can occur, because earlier doses may cause a state of confusion or drowsiness during which additional doses are "unwittingly" taken.[241] This problem is made more acute when the use of barbiturates is accompanied by the use of alcohol.[242] Professor Blum further reports that despite reports to the contrary, he is unaware of any verified cases of "crimes against persons or property occurring because of barbiturate ingestion," [243] but that, particularly when the use of alcohol is also involved, there may be some relation between barbiturate use and dangerous driving.[244]

While he indicates that there have been substantially fewer suicides and accidental deaths by tranquilizers than by barbiturates,[245] Professor Blum's observations with respect to tranquilizers generally parallel his observations with respect to barbiturates.[246] He stresses that "there is no reliable evidence to the effect that tranquilizers are associated with antisocial behavior." [247] He further points out that there is probably considerable unsupervised use of tranquilizers and that United Nations and World Health Organization personnel believe that "users of tranquilizers tend to be middle and upper class respectable persons." [248]

Amphetamines are stimulants. The Subcommittee on Narcotics Addiction of the Medical Society of New York County has reported: [249]

> Amphetamines produce no true addiction but they are habituating and dangerous. Judgment and intellectual impairment, aggressive behavior, incoordination, and hallucinations all may occur during habituation. A variety of symptoms may also occur during withdrawal. Furthermore, amphetamines are being implicated in increasing numbers of automobile accidents.

While it is generally held that amphetamine abuse does not involve physical dependence,[250] there is some opinion that it may.[251] Professor Blum reports that withdrawal symptoms occur rarely, but psychological dependence does occur.[252] He also reports that amphetamine psychosis is a real risk,[253] and that self-medication by persons seeking to combat fatigue and overweight is apparently widespread.[254] On the basis of an analysis of primary sources he states:[255]

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[232] In "The problems of barbiturates in the United States of America," 16 Bulletin on Narcotics, No. 1, 17 (January–March 1964) Dr. Joel Fort states (at 20):

> Figures and information [referred to earlier in the article] would tend to indicate that amounts of barbiturates far in excess of therapeutic needs are being produced and distributed. In doing the research for this monograph, it can be said that I learned much more about what is not known concerning the abuse of barbiturates than about what is known. As is brought out in a recent book on narcotics, there is an astonishing lack of accurate and complete data, a predominance of opinion rather that fact, emotion rather than reason, lack of planning, omissions, duplications, and misuse of statistics. If this can rightly be said about the use and abuse of narcotics in America, it is all the more true about the problem of barbiturates. A special ad hoc panel on drug abuse appointed in 1963 by President Kennedy stated in its report [Ad hoc Panel on Drug Abuse, Progress Report (1962)] that the present records of various agencies connected with drug abuse are frequently inaccurate, incomplete and unreliable, generally limited to individuals apprehended by enforcement agencies, and uncoordinated with other agencies, thus demonstrating a marked need for a standard core of information common to all record systems. They go on to state that there are large numbers of drug abusers who never come to the attention of the community; that there is an increasing abuse of non-narcotic drugs * * *; that there is an entirely new and increasing abuse of drugs periodically on a spree basis * * *.

[233] The President's Advisory Commission on Narcotic and Drug Abuse in its final report merely stated that there had been an "apparent increase in the abuse of dangerous drugs" (at 35), and

> No one knows exactly how many drug abusers there really are in the United States. The number of narcotic addicts alone is estimated to be between 45,000 and 100,000. The total number of drug abusers would be much greater. It includes narcotics users who are not addicts and the many abusers of non-narcotic drug. (At 4.)

Dr. Fort states:

> One physician's estimate is that there are at least 1 million people taking sleeping pills in this country, with 10–25 percent of the habitual users being unsuspecting addicts. Another has said that there are 50,000 "true addicts" and many more habitués. Fort, supra note 232 at 20.

In the Senate debate on H.R. 2, Senator Dodd stated that unnamed Federal and State agencies estimated that there were over 100,000 habitual users of dangerous drugs in the United States. 111 Congressional Record 14094, cols. 2 and 3, 89th Cong., 1st sess. (Senate) (daily ed. June 23, 1965). The Narcotic Drug Study Commission of the New Jersey Legislature has said, "Estimates of heroin addicts in the country average about 60,000 and probably there are greater numbers of people who misuse barbiturates." 1965 N.J. Report at 73.

It should be stressed that not all abusers of "medically" depressant and stimulant drugs obtain their drug supplies from illicit markets. See Winick, "Narcotics addiction and its treatment," 22 L. & C.P. 9, 13 (1957).

[234] "Self-medication" would include such conduct as (*a*) occasionally taking a controlled drug prescribed for another member of the family or otherwise intended for another person for a real or imagined ailment or condition, or (*b*) prevailing upon a pharmacist to refill a prescription because it is believed that what has helped a condition in the past will help what is believed to be the same condition. As used herein the term presupposes "self-diagnosis."

[235] E.g., Essig, "Addiction to nonbarbiturate sedatives and tranquilizing drugs," 5 Clinical Pharmacology and Therapeutics 334 (1964); Fort, "Social and legal response to pleasure-giving drugs," in Blum (ed.), Utopiates 205, 211 (1964); Fort, "The problem of barbiturates in the United States of America," 16 Bulletin on Narcotics, No. 1, 17, 25 (January–March, 1964); Fraser and Grider, "Treatment of drug addiction," 14 Am. J. of Med. 571, 572 (1953); Isbell and White, "Clinical characteristics of addictions," 14 Am. J. of Med. 558, 562 (1953); Isbell, "Abuse of barbiturates," 9 Bulletin on Narcotics, No. 2, 14 (April–June 1957); anon., "The problem of barbiturates in the United States of America." Id., p. 15.

[236] Essig, note 235 supra.

[237] The Subcommittee on Narcotics Addiction of the Public Health Committee of the Medical Society of the County of New York has reported:

> Every year there are 3,000 deaths due to accidental and intentional overdose of barbiturates but a far more common problem is habituation and addiction. Barbiturate addiction, defined by physical dependence, is characterized by intellectual impairment, self-neglect, slurred speech, tremor, defective judgment, bizzare behavior and ataxia. Those who treat it consider it a nasty addiction, often characterized by excessive activity, agitation, and by aggressive, sometimes paranoid behavior. Withdrawal, if abrupt, may produce nausea, vomiting, weakness, tremulousness, insomnia, fever (up to 105 degree F) delerium, hallucinations, and, most dangerous of all, convulsions, stupor and coma which may be fatal.

N.Y. Medicine 22, No. 9, 3, 4 (May 5, 1966) (hereinafter "N.Y. C'ty Med. Soc'y Report").

[238] See Testimony of Dr. John Griffith, Director, Oklahoma Mental Health Planning Committee, Hearings at 312–13; Goodman and Gilman, The Pharmacological Basis of Therapeutics 298 (amphetamines), 305–06 (barbiturates and amphetamines) (3d ed. 1965); Fraser and Grider, "Treatment of drug addiction," 14 Am. J. of Med. 571, 576 (1953); Isbell and Fraser, "Addiction to analgesics and barbiturates," 2 Pharmacol. Rev. 355, 390 (1950).

[239] See note 233 supra.

[240] Blum Report at 54.

[241] Id., at 54–55.

[242] See Blum Report at 56.

[243] Id., at 55.

[244] See Blum Report at 55–56.

[245] Id., at 48–49.

[246] See Blum Report at 47–52.

[247] Id., at 49.

[248] Blum Report at 48. See also Fort, "Social and legal response to pleasure-giving drugs," in Blum (ed.), Utopiates 205, 211 (1964).

[249] N.Y. Med. Soc'y Report, 22 N.Y. Medicine No. 9, at 4 (May 5, 1966).

[250] See, e.g., note 249 supra; Smith, Kline, & French Laboratories, Handbook on Dexedrine, etc., 20–25 (1966).

[251] Goodman and Gilman state:

> For a long time it was believed that, except for craving, general fatigue, lassitude, and depression, there were no withdrawal symptoms from amphetamine-like drugs. However, in 1963 Oswald and Thacore observed that after abrupt withdrawal of large doses of amphetamine the EEG pattern during sleep shows a consistent, significant increase in the percentage of the rhombencephalic phase (that time during which low-voltage, fast activity is associated with rapid eye movements). This percentage returns to normal levels when amphetamine is given, and rises again when amphetamine is withheld. This phenomenon meets the usual criteria for a withdrawal symptom but does not alter the fact that abrupt discontinuation of sympathomimetic amines does not cause major, grossly observable, physiological disruptions that would necessitate the gradual reduction of the medication.

The Pharmacological Basis of Therapeutics 298 (3d ed. 1965).

> Research done to date directly contradicts the claims linking amphetamine use of crimes of violence, sexual crimes, or to accidents.

It is recommended that unauthorized use of "medically depressant or stimulant drugs" should not be a criminal offense. It is also recommended that simple possession should not be an offense, because it, in effect, punishes the user for his use. Every medically unauthorized user is subject to prosecution where simple possession is a crime even if use is not. To the extent that simple possession punishes the user for his conduct in obtaining drugs from illicit channels, it is believed that the reasons for not punishing the user for his use outweigh society's interest in punishing the user's conduct in so obtaining drugs. But, if the user obtains drugs by committing an independent offense such as larceny or robbery or obtains drugs by misrepresentation or deception it is believed he should be subject to punishment.[256]

The Relationship Between Possession and Distribution. Assuming that punishment for use and for improperly obtaining drugs is deemed undesirable, the only justification for a simple possession offense is its relationship to later distribution by the possessor. From this point of view, punishment for simple possession is also deemed inappropriate, because for the purpose of punishing distribution, it prohibits conduct (i.e., possession) which is deemed preparatory to distribution (1) while making irrelevant proof of whether distribution was in fact the ultimate end of the prohibited conduct and (2) when that conduct may be ambiguous in its relation to that end.

The mere fact of possession of a drug (the conduct prohibited) is ambiguous as indicating whether possession is for the purpose of distribution, and a simple possession offense makes irrelevant proof of the actual purpose of the possession. While the quantity of drugs possessed or other circumstances may indicate that possession was for distribution, a simple possession offense does not require proof of such factors. A person commits the offense if he possesses one pill without a prescription even though there is no proof that he possesses to distribute. If a possession offense is viewed as aimed at distribution, liability is based on conduct which is ambiguous in relation to the ultimate evil at which the offense is aimed, and there is strict liability as to that evil.[257] Where the offense is possession with intent to sell or otherwise distribute or in the similar situation where possession for personal use is excepted from liability as it is under the 1965 Federal Drug Abuse Control Amendments these objections are absent.

Addiction and Punishment. It is generally recognized that loss of control over the use of a drug—often called addiction where there is both physical and psychological dependence, and habituation where there is psychological dependence without physical dependence—is, regardless of the particular drug involved, a disease. Both chronic alcoholism and narcotics addiction are usually recognized as diseases.[258] The American Medical Association has said that opiate addiction is "a medical syndrome based on an underlying emotional disorder," [259] and that it has "the characteristics of a chronic relapsing psychiatric disorder." [260] There is no reason to distinguish the loss of control over the use of a nonnarcotic drug from the loss of control over alcohol or narcotics in this regard.

It would seem inappropriate to invoke the criminal process against persons who have lost control over the use of dangerous drugs solely because these persons are drug users. Once a person has lost control over his use the existence of a user offense such as use or simple possession will not deter his use. Having lost control, he cannot choose to conform his conduct to the requirements of the law by refraining from use. He is nondeterrable.[261]

Admittedly, there may have been a time in his past before he lost control over his use when he did have a choice to use or not to use, or to stop using. Because of this, punishing him for use or simple possession would not offend the principle that to be punishable, conduct must be volitional. However, it would remain that to punish on this basis would still be to punish a nondeterrable, and to punish for conduct which may have taken place a long time in the past.

Deterrence and Condemnation. It might be argued that criminal treatment of use or simple possession by either the user who has lost control over his use or the user who still has control is justified by the possibility that it will deter some persons who have not yet taken their first dose or otherwise still have choice. It is likely, especially if a few cases are prosecuted, that some such persons will be deterred if use or simple possession is a crime, but it must be recognized that we know so little about deterrence, particularly as it affects addiction-prone or susceptible persons, that we can only speculate.[262] It should be recognized that there may also be persons who are affirmatively attracted to drug use by the fact that it's illegal. Moreover, self-medication, though unwise, is so common and, in a sense, accepted in the United States that a use or simple possession offense probably would not deter much self-medication involving controlled drugs which are in wide use. While simple possession and use offenses announce a judgment that society condemns and disapproves of nonmedical use of "medically depressant and stimulant drugs," it is submitted that society can also condemn and voice disapproval of nonmedical drug use by educative efforts and especially sanctions against trafficking. Furthermore, although society wants to condemn nonmedical drug use, one may question whether it desires or should desire to condemn or have the public condemn and view as criminals users,[263] or, at any rate, all users. To the extent that drug abuse is a disease or a symptom of a disease, it may not.

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[252] Blum report at 37.

[253] Id., at 38.

[254] Blum report at 33.

[255] Id., at 35.

[256] The subject of obtaining drugs by misrepresentation or deception is discussed in a subsequent subdivision of this report.

[257] If they are viewed as aimed at ultimate distribution by the purchaser, offenses which prohibit unlawfully obtaining or acquiring drugs present these same problems.

[258] E.g., Note, "Alcoholism, public intoxication and the law," 2 Colum. J. of Leg. and Soc. Prob. 109, 112–14 (1966); AMA: Narcotics Addiction, passim: *Robinson* v. *California*, 370 U.S. 660 (1962).

[259] "The use of narcotic drugs in medical practice and the medical management of narcotic addicts". A statement of the American Medical Association's Council on Mental Health and the National Academy of Sciences—National Research Council, in AMA: Narcotics Addiction 53.

[260] Id., at 61.

[261] Unless they otherwise come within established tests of irresponsibility, neither drug addicts nor alcoholics are presently held irresponsible for crime because of their condition. See *United States* v. *Freeman*, 357 U.S. 606, 625 (2d Cir. 1966). But see *Castle* v. *United States*, 347 F. 2d 492 (D.C. Cir. 1964), cert. denied, 381 U.S. 953. Most addicts would be found responsible under these tests. Evidence of intoxication or addiction, however, is generally admissible to negate the existence of a state of mind required for the commission of the crime in question. See Wis. Stat. Ann., § 939.42 (1958); Model Penal Code, § 2.08 (Proposed Official Draft 1962); Comments to Model Penal Code, § 2.08, Tent. Draft No. 9, 12–13 (1959).

The argument advanced in the text might, if carried forward, support the view that loss of control over the use of a narcotic or a dangerous drug should be available as a defense to other charges of crime. The author passes no judgment on this question as it is beyond the scope of his assignment and deserves extensive independent study. While the addict's or habitual user's inability to conform his conduct to the requirements of the law is a weighty consideration against use and simple possession offenses, for the purpose of this study it is assumed that the addict or habitual user may be punished for all offenses subject only to general tests of mental responsibility and the rule that addiction may negate a state of mind required for the offense.

[262] As Prof. Anthony Amsterdam has said in another context: "* * * as though we know anything about the deterrent efficacy of the criminal sanction * * *." Letter to Chief Judge David L. Bazelon of the United States Court of Appeals for the District of Columbia Circuit, July 2, 1965, printed at 54 Kentucky L.J. 496 (1966).

Isolation and Treatment. While little is known about a punitive approach toward users of "medically depressant or stimulant drugs," it may be expected that as in the case of alcoholics and narcotic addicts a punitive approach to users who have lost control over their use will result in a "revolving door" [264] or a repetitive cycle of arrest, release and arrest, or arrest, conviction, imprisonment, release and arrest. In neither the case of alcoholics [265] nor narcotic addicts [266] has it been shown that such a process aids the user to abandon his habit. The only thing that such a process accomplishes is to keep dependent users off the streets for some period of time. In the case of alcoholism it has been referred to as "life imprisonment on the installment plan." [267] If the sole object of this process is to keep dependent users off the streets, that object could be better accomplished either by longer prison terms [268] or by long periods of nonpunitive isolation from society.

Isolation would be based on the view that addicts and habitual users commit crimes and sell drugs to support their habits, or for other reasons, and introduce nonaddicts to drugs. This view has been advanced to support long periods of isolation for narcotics and addicts irrespective of whether a particular addict has committed a crime other than possession or use.[269] In his report to the Commission, Professor Aronowitz shows that the known facts do not warrant such treatment with respect to narcotics addicts.[270] The known facts [271] certainly do not warrant it in the case of addicts and habitual users of "medically depressant and stimulant drugs."

While we know little about the relationship between heroin addiction, on the one hand, and addict crime, selling and proselytizing on the other,[272] we know even less about the relationship between addiction and habitual use of dangerous drugs to these activities. Some persons are addicted to both heroin and barbiturates,[273] and some heroin addicts may use amphetamines to "get a bigger high" [274] or use barbiturates when they cannot obtain heroin.[275] Some barbiturate addicts may commit crimes to support their habits or push drugs; it may be that these addicts are mainly persons who also are addicted to heroin. It appears that some users may proselytize,[276] even if they do not distribute drugs. But no information has come to the attention of the author which indicates how prevalent either proselytizing, or pushing, or committing crime to support a habit is. We have no reliable information as to the number of addicts or habitual users of "medically depressant or stimulant drugs" in the United States.[277] Since it is believed that there is a greater proportion of middle class addicts or habitual users of such drugs than of heroin,[278] it is probable that a smaller proportion of addicts or habitual users of these drugs come to the attention of public authorities than of heroin addicts. About those who do not come to the attention of public authorities little is known. It would appear that members of this group would more likely be able to secure drugs through medical channels,[279] and that in many cases where drugs are so obtained they will be purchased from a pharmacist pursuant to prescription at normal prices.

In addition, it is unclear to what extent the price of "medically depressant or stimulant drugs" in illicit markets is such that abusers have to support their habits by criminal activities. While it is possible that the regulation imposed by the recordkeeping provisions of the 1965 amendments will lead to an increase in prices in illicit markets, one cannot predict whether prices will rise to such an extent that it will become necessary generally for users to resort to crime in order to support a habit. Finally, Professor Blum has pointed out that although it is possible that such drugs may impair driving, there is virtually no evidence of crimes against the person or property by persons under their influence.[280]

On the basis of available evidence, the fear that some abusers of "medically depressant or stimulant drugs" will sell or commit crimes either to support their habits or for other reasons, or engage in other antisocial conduct does not justify subjecting them to long periods of isolation either in a punitive or a nonpunitive custodial scheme. Nor do considerations of treatment justify their nonpunitive isolation.

In his report to the Commission, Professor Aronowitz pointed out that such considerations do not justify nonpunitive isolation for the narcotic addict, because treatment prospects are extremely poor under known methods.[281] This conclusion applies equally to treatment of addicts and habitual users of "medically depressant or stimulant drugs," for at the present time, it does not appear that treatment prospects for such persons, are any better than for narcotic addicts.[282]

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[263] An added consequence of present procedures with all the drugs but alcohol is to create in the illicit user a negative self-image and added difficulty in finding employment, which perpetuates and intensifies any pre-existing social alienation. Fort, "Social and Legal Response to Pleasure-Giving Drugs," in Blum (ed.), Utopiates 205, 221 (1964).

[264] The history of the term is given in Note, "Alcoholism, public intoxication and the law," 2 Colum. J. of Law and Soc. Prob. 109, 110 and n. 13 (1966).

[265] See Id., at 130–31.

[266] Nor do long periods of imprisonment aid the narcotic addict to abandon his habit. See Remarks of Senator McClellan, 112 Congressional Record 24405, 89th Cong., 2d sess. (Senate) (daily ed. Oct. 6, 1966).

[267] The phrase is apparently attributable to Judge Bernard Botein, Presiding Justice of the Appellate Division, First Department of the New York Supreme Court. See Note, "Alcoholism, public intoxication and the law," 2 Colum. J. of Law and Soc. Prob. 109, 110 (1966).

[268] The purpose of such prison terms would not be to aid the user to abandon his habit. See note 266 supra.

[269] See, e.g., the authorities cited in Aronowitz, Civil Commitment of Narcotics Addicts and Sentencing for Narcotic Drug Offenses: Report for the President's Commission on Law Enforcement and Administration of Justice n. 12 (Aug. 6, 1966) (hereinafter "Aronowitz Report") (Citations are to manuscript.).

[270] Aronowitz Report at 2–12.

[271] See the quotation from Dr. Fort in note 232 supra.

[272] It is not known what proportion of narcotic addicts commit crime other than use or possession or introduce others to drugs. While a number of narcotic addicts coming to the attention of the police push to maintain their own habits and while addicts are apparently one source by which heroin is distributed, we do not know how many narcotic addicts there are in the United States, and undoubtedly there are addicts who do not come to the attention of the police or other public authorities. Aronowitz Report at 2–12.

[273] E.g., Goodman and Gilman, The Pharmacological Basis of Therapeutics 296 (3d ed. 1965); Hamburger, "Barbiturate use in narcotic addicts," 189 J.A.M.A. 366 (1964).

[274] See The Drug Takers 11 (Time Inc. 1965).

[275] Goodman and Gilman, The Pharmacological Basis of Therapeutics 292 (3d ed. 1965).

[276] Telephone interview with Dr. Richard Blum. See also Blum (ed.), Utopiates, passim (1964).

[277] See notes 232 and 233 supra.

[278] It has been stated that "Although adequate data are lacking, abusers of barbiturates and amphetamines probably include more medical (doctor-dependent) abusers and fewer 'street' users than is true for opiate abusers." NIMH, Report on Treatment of Narcotic Drug Addiction for the President's Crime Commission, at 22 (revised as of June 6, 1966) (Citations are to manuscript.).

[279] Cf., Winick, "Narcotics addiction and its treatment," 22 L.S.C.P. 9, 13 (1957).

[280] Blum Report at 35 (amphetamines), 49 (tranquilizers), 55 (barbiturates).

[281] Aronowitz Report at 8.

[282] See the authorities cited in note 238 supra.

It must be emphasized that even were the evidence which might support long periods of isolation for use or possession by addicts and habitual users of such drugs clearer, a determination that a person could be isolated merely because he has lost control over the use of a drug would depart from principles which at the very least require a determination that the particular individual to be isolated poses a danger to himself or to society.

If it is feared that dangerous drug abusers will introduce nonusers to drugs and distribute drugs, they may be punished for trafficking offenses including possession for the purpose of sale or distribution. If it is feared that use will lead to crime, the user may, unless he should be determined irresponsible, be punished for the crimes he commits. If particular abusers are dangerous to themselves or others because of mental illness or otherwise meet general requirements for hospitalization of the mentally ill, they should be treated as other mentally ill persons and isolated for the safety of society and of themselves and for any possible treatment that may be afforded to them. If they only possess or use drugs and are not sufficiently disturbed by their use to meet usual standards for commitment as mentally ill, or as long as there is little likelihood that they can be successfully treated, they should not be subjected to nonpunitive isolation.[283]

Self-Medication and Common Use. Possession and use offenses make crimes of conduct (such as self-medication) which is (1) rather widespread and (2) though certainly undesirable, is not necessarily an indication of any or at least an appreciable aberration from what is normal in our society. Whether it is wise policy for the criminal law to reach such conduct is very questionable.

Although the legislative history of the possession provision of the 1965 Federal amendments is by no means clear on the point, apparently possession for personal use was at least in part exempted from the prohibition, because given the widespread use of "medically depressant or stimulant drugs" and the extent of self-medication in the United States, a simple possession provision would make criminals of a large number of persons for undesirable but rather "normal" conduct, and perhaps also because of difficulties of enforcement against such persons, the fear that prohibition of such conduct might not be taken seriously, and the belief that punishment would not benefit the user.[284] Conversations between the author and FDA officials who were involved in the formulation of the amendments revealed that a desire not to reach conduct which is so common and the belief that some users were ill persons lay behind the exception. On more than one occasion the American experience with prohibition of alcoholic beverages was referred to in Congress. One representative in pointing out that the legislation did not apply to users even if they obtained drugs improperly, stated "we have to keep in mind and avoid the unfortunate experience this country had in its attempted regulation of alcoholic beverages."[285] The report of the House Commerce Committee on H.R. 2 stated:[286]

> The committee is mindful of the difficulties which this country had in its attempted regulation of alcoholic beverages, and therefore, has provided for regulation of depressant and stimulant drugs by increased recordkeeping and inspection provisions rather than by imposing more rigid controls. The legislation does not apply to the ultimate consumer of these drugs, even when he acquires them through illicit channels, but imposes controls upon all in the chain of distribution from the manufacturer down to (but not including) the user.

The desire not to make the user a criminal for small and fairly common derelictions appears in the testimony of William W. Goodrich, then Assistant General Counsel of the FDA during the hearings held on the 1965 amendments before the House Commerce Committee:[287]

> Mr. Satterfield. Wouldn't you be in a better position from an enforcement standpoint if you could make it illegal to have it in possession without the prescribed prescription?
>
> Mr. Goodrich. This sort of an idea was considered before. Since we were concerned with commercial distribution, it was decided that it would be best to put it in terms as it is in the bill, rather than make it so wide open that if you got your druggist to give you six pills without a prescription you would be a criminal. That is the idea of this provision.
>
> The Chairman. What this would do is to get that druggist and not to the man who may have a half dozen pills for his own use.
>
> Commissioner Larrick. That is the point.
>
> The Chairman. But if the man who gets it illegally, then proposed to distribute it illegally, it does reach him.
>
> Commissioner Larrick. That is the point. We could prove it probably by the large volume in his possession as well as by an actual sale.

Apparently, similar views lay behind the decision to omit a simple possession prohibition from the 1961 Canadian Federal legislation controlling the distribution of barbiturates and amphetamines. The Chief of the Division of Narcotic Control of the Canadian National Department of Health has written of it:[288]

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[283] See Aronowitz Report at 8.

[284] During the testimony of Dr. John Griffith, Director of the Oklahoma Mental Health Planning Committee, before the House Commerce Committee, Dr. Griffith was asked by Chairman Harris of the committee whether he thought simple possession should be punishable:

> The Chairman. Suppose you catch an addict with some. He is the user, and he obtained them from a peddler.
>
> Dr. Griffith. Punishing him is not going to change the situation materially.
>
> The Chairman. I am inclined to agree with you.

Hearings at 316.

[285] Statement of Representative Minish of New Jersey, III Cong. Rev. 4580, col. 1, 89th Cong., 1st sess. (House) (daily ed. Mar. 10, 1965).

[286] House Report at 3.

[287] Hearings at 362.

[288] Hammond, "The control of barbiturates and amphetamines in Canada," 15 Toronto L.J. 443, 445 (1964). The Canadian act prohibits trafficking and possession for the purpose of trafficking. The procedure in a prosecution for possession for the purpose of trafficking under the Canadian act is outlined in it as follows:

> 33. (1) In any prosecution for a violation of sub. (2) of sec. 32 [possession for the purpose of trafficking] if the accused does not plead guilty, the trial shall proceed as if the issue to be tried is whether the accused was in possession of a controlled drug.
>
> (2) If pursuant to sub. (1) the court finds that the accused was not in possession of a controlled drug, he shall be acquitted but if the court finds that the accused was in possession of a controlled drug, he shall be given an opportunity of establishing (*a*) that he acquired the controlled drug from a person authorized under the regulations to sell or deal with controlled drugs; or (*b*) That he was not in possession of the controlled drug for the purpose of trafficking and thereafter the prosecutor shall be given an opportunity of adducing evidence to the contrary.
>
> (3) If the accused establishes the facts set forth in paragraph (*a*) or (*b*) of sub. 2 he shall be acquitted of the offense charged; and if the accused fails to establish he shall be convicted of the offense as charged and sentenced accordingly.
>
> 34. * * *
>
> (2) In any prosecution under this part the burden of proving an exception, exemption, excuse or qualification prescribed by law operates in favour of the accused, and the prosecutor is not required, except by way of rebuttal, to prove that the exception, exemption, excuse or qualification does not operate in favour of the accused, whether or not it is set out in the information or indictment.

"An Act to Amend the Food and Drugs Act," 1961, 9–10 Eliz. II, ch. 37, §§ 33, 34.

> An offense of "straight possession" was not provided for in the act. The wide acceptance and use of some forms of barbiturates in medical treatment, as a mild sedative, influenced this decision. Moreover, it has been a common, although unwise, practice in many households to exchange medication prescribed by physicians for family members with other relatives.

A simple possession or use offense for "medically depressant and stimulant drugs" would, as Mr. Goodrich said, "make it so wide open that if you got your druggist to give you six pills without a prescription you would be a criminal." It would also make a criminal the man who on one night could not sleep and took one of his wife's barbiturates. In short, it would prohibit the common conduct of people who are normal in our society or who at most vary only insignificantly from the norm.[289] It is unlikely that the prohibitions could or would be enforced in situations like those just mentioned. When such a case is singled out, prosecution might smack of unequal enforcement.[290]

A prosecutor may use his discretion to screen out cases which are not appropriate for enforcement, and, perhaps, in some cases perform the service of convincing users to seek medical help. Use or simple possession offenses may also identify persons who are disturbed. However, on balance, it is believed that a simple possession or use offense would cover so much conduct which ought not to be prosecuted that the possibilities of abuse outweigh these considerations.

Both self-medication and the practice of occasionally obtaining controlled drugs from a pharmacist without a prescription are, of course, to be discouraged. It is submitted, however, that the conduct involved is not, and is not regarded by the community as so blameworthy that it should constitute a criminal offense.

Law Enforcement. In addition to arguments based on deterrence and the need to condemn use, it is argued by some law enforcement agencies that a simple possession offense, if not a use offense, is necessary to effective law enforcement against the trafficker. The reasons for this view are several. First, simple possession and use offenses obviate the necessity of proof of a sale or that possession was for the purpose of distribution. Therefore, they make it easier to prove cases against suspected traffickers.[291] Second, and related, law enforcement officers drawing on their experiences with heroin distribution may assume that except at higher levels of distribution there will be some identity between possessors and sellers and, therefore, that punishing possession will punish a large number of sellers.[292] Whether or not this assumption is justified, it would lead to utilization of a simple possession or use offense against the user because proof is easier. Third, the existence of such offenses furnishes an incentive for a person picked up for simple possession or use to cooperate with the police by disclosing to them his source of supply.

While the relative ease of proving simple possession or use and the incentive such offenses give for cooperation do make law enforcement simpler,[293] the question still remains how necessary for effective law enforcement they are. Officials of the Federal Food, Drug, and Cosmetic Administration expressed the belief that the FDA can control the traffic in "depressant and stimulant drugs" with the tools given to it by the 1965 amendments, and only if experience should prove these tools inadequate would it seek additional legislation. It was said that it was "not too difficult" to make a case against a pusher and that it was FDA policy to make a case by undercover work which usually culminates in a "buy."

It was also believed that pushers can be reached under the Federal possession provision. One official, however, believed that proving a case under that provision would prove difficult. The same officials, one of whom has experience in State law enforcement of dangerous drug laws, pointed out that State enforcement officials generally favored a simple possession offense, because such an offense makes it easier to prove a case and to secure leads to sources. They also noted that State agencies which enforce drug laws are often hampered in their enforcement efforts by insufficient staff.

While it is recognized that the staff problems of some State law enforcement agencies make law enforcement more difficult for them than for the Federal Government, it is believed that the same reasons which make use and simple possession offenses inappropriate for Federal criminal treatment make them inappropriate for criminal treatment by the States.

It is to be hoped that the staff situation at the State level will improve, and it is expected that close cooperatin between the FDA and State enforcement agencies will help to make for more effective law enforcement. (The FDA is about to embark on a pilot program of extremely close cooperation with State agencies in several areas of the country.)

Moreover, it is suggested that any losses in reaching traffickers which may occur because of the absence of use or simple possession at the State level will not cripple efforts at controlling illicit traffic in dangerous drugs. The FDA is primarily concerned with large-scale trafficking, and the States and municipalities are primarily concerned with "retail" traffic. The greater undercover work which is probably required when use and simple possession are not prohibited will probably yield a greater return in the former, because illicit traffic can be disrupted more by apprehending large-scale traffickers and seizing their wares than in apprehending small peddlers. This suggests that if the absence of such offenses should result in failure to apprehend or convict some suspected traffickers, the greater loss will occur at the levels of distribution where it is most tolerable.

While it is unlikely that the possession provision of the Federal amendments will reach all sellers, it is believed that it can be used effectively. It will probably be most effective in cases where the possession is of large quantities or where there is other evidence that possession was for the purpose of sale or distribution. Since some addicts and habitual users of "medically depressant or stimulant drugs" may take considerable amounts and may have relatively large supplies of drugs in their possession for their own use, there will be cases where possession of fairly large amounts will be as consistent with innocence as with guilt. However, as quantity increases, the inference that possession was for distribution is strengthened. While some persons who in fact are sellers may escape liability in cases based on ambiguous quantities, it is submitted that this is necessary to avoid a liability that is based solely on conduct ambiguous in its relation to the evil at which it is aimed.

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[289] In terms of drug use the rarest or most abnormal form of behavior, based on our own research, is not to take any mind-altering drugs at all.
Blum Report at 8.

[290] Women whose pregnancies have not continued beyond the 26th week were exempted from liability for self-abortion under the Model Penal Code, in part because

> * * * exemption is the honest statement of the present and foreseeable law enforcement, so that district attorneys and other responsible officials should not face the problem of the mother's liability as one of discretion.

Comments to Model Penal Code, § 207.11 (now § 230.3), Tent. Draft No. 9, 159 (1959).

[291] Testimony of Dr. John Griffith, Director, Oklahoma Mental Health Planning Committee, Hearings at 316; Blum Report at 29.

[292] See Ibid. However, in a letter to the author dated July 25, 1966, and quoted at length in note 301, infra, Senior Inspector Alfred J. Murphy of the Drugs Control Section of the Massachusetts Department of Public Health stated, "Possession for one's own use is not difficult to discern from possession with intent to sell in actual field operations."

[293] There is some reason to believe that at least in some areas of the country committing magistrates would hold possessors under a statute like the federal prohibition provision even when the quantity possessed is probably not enough to warrant an inference that possession was for the purpose of distribution. Cf., Dash, "Cracks in the foundation of criminal justice," 46 Ill. L. Rev. 385, 388–89 (1951); Goldstein, "The state and the accused: balance of advantage in criminal procedure," 69 Yale L.J. 1149, 1166–69 (1960); Note, "Philadelphia police practice and the law of arrest," 100 U. Pa. L. Rev. 1182, 1183 (1952). To the extent that arrests are made, charges lodged and magistrates so respond, "incentives for cooperation" may be present even under such a provision. When the quantity possessed is large or the accused otherwise believes that prosecution may be successful, such an incentive will, of course, also be present.

Burden of Proof, Presumptions, and Quantity Limitations. Under the Federal possession provision the Government carries the burden of proving that possession was not for an excepted purpose. This provision is desirable. Problems involving the allocation of both the burdens of persuasion and coming forward "have as large a substantive as adjective dimension." [294] Were the burden of persuasion to be shifted to the defendant,[295] it is believed that some number of defendants who did not have prescriptions for the drugs they possessed but who were only users and not sellers could be convicted. In operation, such a provision might become very close to a simple possession provision.

A statutory requirement making possession for personal use an affirmative defense and relieving the prosecution of the burden of producing evidence of the purpose of possession in the first instance would not seem warranted.[296] Such a requirement could not be justified on the basis that claims that possession was for personal use are likely to be exceptional; such claims will probably be fairly frequent, depending in large part upon the quantities involved in particular cases. It is recognized that where the offense is simple possession it might be argued that the defendant should come forward with evidence that his possession was under a prescription, because it is difficult to prove a negative; however, the situation under a provision like the Federal provision is different. Although nominally the Government must prove a negative, it will in effect usually be attempting to prove that possession was for the purpose of distribution. While the fact that shifting the burden of initially coming forward puts pressure on the defendant to testify may perhaps not be decisive,[297] it too militates against such a requirement. Finally, such a requirement could not be said to be uniformly fair. It would be unfair when the Government proves unauthorized possession of only one or two pills and nothing more in its direct case, because if such proof suggests anything, it suggests that possession was for personal use. These considerations also suggest that a presumption assuring that the issue of the purpose of the possession will be submitted to the jury upon proof of unauthorized possession of any quantity of a controlled drug, no matter how small, would be inappropriate.[298]

It is not believed that possession of a specified minimum quantity of a drug should in itself constitute a crime or be designated by statute as prima facie or presumptive evidence of a possession for sale or distribution offense. This recommendation is only in part based on the view, drawn from experience with such statutes in the narcotics field, that peddlers will make sure to carry less than the quantity named.[299] The then executive secretary of the Ohio board of pharmacy has informed the author that the possession for sale provision of the Ohio Dangerous Drug Distribution Act (which makes possession of more than 150 times the usual dose presumptive evidence that possession was for sale) has worked well, even though there have been some instances where pushers have taken care to carry around less than that number.[300] To the extent, however, that pushers do take care to carry around less than the minimum where there is a quantity provision, the Federal provision would seem preferable. Quantity will be significant under the Federal provision. Some cases may be based entirely on it, and it is to be expected that the Federal courts will evolve some guidelines on quantity. It is unlikely, however, that these guidelines will be as inflexible as a minimum quantity denominated in a statute. Presumably, in some number of cases quantity will be only one factor in proving the purpose of possession.[301] Hence, under the Federal provision, it appears less likely that a peddler can be confident that he is insulated from prosecution by the quantity he is carrying.

There is a more fundamental objection to a quantity limitation. Perforce, any quantity limitation must be arbitrary. If the minimum is low enough to reach almost all peddlers, it will probably also reach a not insignificant number of nontrafficking users and situations where the possession involved in the charge was for personal use. If it is high enough to exempt almost all nontrafficking users it will probably exempt some peddlers too. Thus, a provision like the Federal provision which allows all the circumstances to be taken into account would seem preferable.

A quantity provision making possession of a minimum amount prima facie evidence of violation, but expressly or by implication permitting the purpose of possession to be proved in other ways, would at first glance seem to obviate some of the weaknesses of a provision where violation depended on quantity alone. However, it is believed that if a statute at all mentions quantity, prosecutors and trial judges will in actual practice tend to look at proof of quantity as the sole method of proof,[302] or at least that proof will be difficult in cases in which the defendant did not possess the quantity named, and prosecutors will be reluctant to prosecute in such cases. It also may be anticipated that where the defendant did possess the quantity named it will be a rare case where he will avoid conviction even if he offers evidence of the purpose of the possession.

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[294] Comments to Model Penal Code, § 1.13 (now § 1.12), Tent. Draft No. 3, 108 (1955).

[295] There may be some doubt as to whether this would be constitutionally permissible. Cf., note 370 infra. But see *Leland* v. *Oregon*, 343 U.S. 790 (1952).

[296] On the constitutional propriety of such a provision, see note 370 infra.

[297] Comments to Model Penal Code, § 1.13 (now §1.12), Tent. Draft No. 4, 112 (1955).

[298] On the constitutional standard for testing the validity of such a presumption, see note 370 infra.

[299] *Hutcherson* v. *United States*, 345 F. 2d 964, 971, 975 and n. 21 (D.C. Cir. 1965), cert. denied, 382 U.S. 894 (separate opinion of Bazelon, J.); Eldridge, Narcotics and the Law 52–56 (1962).

[300] The Secretary stated that enforcement officials, alerted to the suspect's possession, observe him until he either possesses the requisite quantity, sells, or leads them to his source. Letter of Dr. Rupert Salisbury, then Executive Secretary of the Ohio State Board of Pharmacy, to the author, dated June 30, 1966.

[301] In a letter to the author dated July 25, 1966, Alfred J. Murphy, Senior Inspector, Drugs Control Section, Massachusetts Department of Public Health, stated that under the Massachusetts possession with intent to sell provision (which does not refer to quantity) the purpose of the possession may be proved by "a quantity of pills far above the normal amount for self-medication or abuse" and by other evidence of intent to sell. This other evidence may include prior sales and offers to sell. Inspector Murphy further stated:

> Possession for one's own use is not difficult to discern from possession with intent to sell in actual field operations. The user very rarely has sufficient funds to purchase large quantities 500 or more tablets [sic] and usually goes to his or her home immediately after scoring. The user very rarely carries more than two dozen tablets on his person at a time. Amounts over this are usually stashed in several readily accessible places around his home.

[302] In a letter to the author dated Aug. 1, 1966, Dr. Rupert Salisbury, then Executive Secretary of the Ohio Board of Pharmacy informed the author that proof of prior sales are admissible under the Ohio possession for sale provision. That provision, of course, makes possession of more than 150 dosage units presumptive evidence of guilt. While Dr. Salisbury did not state to what extent cases are prosecuted where the possession in question is of a lesser quantity, Mr. William Pearce of the board informed the author during a telephone conversation that there is no prosecution for possession for sale in this situation.

Redrafting. Because despite its wording, the Federal possession provision in reality creates the offense of possession with intent to sell or otherwise dispose of a controlled drug, it is believed that it should be redrafted in that fashion. Of course, if the exemption for possession for use of a household member or an animal owned by the possessor or a member of the household is to be retained, the new language should be so qualified.

A Civil Violation. Should the Commission determine that the law must condemn use by a sanction against the user, it would be preferable to do so by the creation of a civil violation carrying with it no deprivation of personal liberty whether by incarceration or other restriction, but enforceable by some other sanction such as fine. In this event, or in the event that the Commission decides that criminal treatment is warranted, it is strongly recommended that it endorse a meaningful precharge conference such as was recommended by Professor Goldstein in his preliminary report to the Commission [303] so that the administrative or criminal charge can initiate meaningful and not necessarily punitive dispositions of offenders (as, for example, referrals to private agencies). Such a procedure should also be applicable to any offense or violation involving the possession or use of LSD or other hallucinogens, including marihuana.

Possession for Household or Animal Use. It is recommended that the exception to the Federal possession offense for possession for use of household members and for administration to household animals should be retained for controlled drugs which are used in the ordinary practice of medicine. While it is undesirable for a person to give a tranquilizer or barbiturate prescribed for him to another member of his household, the practice is so common that it is not believed the criminal laws should reach it.

The existing Federal law contains an anomaly in that the disposition prohibition provision of the 1965 amendments simply provides that no unauthorized person shall "sell, deliver, or otherwise dispose" of any controlled drug "to any other person." [304] While possession for the use of another member of the household is excepted from the possession provision, there is no similar exception in the disposition prohibition, and if a man actually gave a tranquilizer to his wife, it could be deemed a delivery or other disposition. Consequently, an exception similar to that contained in the possession prohibition should be added to the prohibition on disposition.

It should be recognized that the same reasoning which supports the exemption of possession for use of a member of the possessor's household may also support the exemption of possession for use of a friend. This suggests that legislation might prohibit only commercial distribution and possession for commercial distribution or distribution for profit and possession with intent to distribute for profit. With some hesitation, it is not believed that such a course should be taken. In addition to the problems of proof that might be encountered, it is possible that some distributions by addicts and habitual users could not be reached. Although in exempting from punishment possession for use of another member of the household the law probably already exempts some distributions by these persons, and although the author has reservations about whether the criminal law should reach noncommercial distributions by them, it is very questionable whether an approach which would enlarge the current exemption would at the present time be acceptable to the community.

LSD

On the basis of knowledge that is still very incomplete, it appears that the use of LSD, unlike the use of marihuana in the United States,[304a] can have very dangerous effects. LSD has apparently precipitated psychotic reactions, some of which seem to be temporary, others requiring long-term hosptalization.[305] There are also reports of return of the LSD state without renewed use of the drug.[306] Use appears to be increasing.[307] However, it is not known with what frequency adverse reactions take place or how extensive use is; [308] it may be that a significant percentage of persons who have taken the drug have such reactions, or the percentage may be small. And Professor Blum reports that "crime associated with hallucinogen use appears to have been minimal." [309]

In some respects, whether simple possession or use of LSD should be an offense is a more difficult question to answer than the similar question posed with repect to the commonly used "medically" depressant and stimulant drugs. The possible effects of use may be deemed by some more undesirable than the effects of addiction to barbiturates or nonbarbiturate sedatives or habituation to amphetamines. Upon this question the author does not pass judgment. Unlike the "medically" depressant and stimulant drugs, which have to date been controlled, LSD does not have widespread legitimate use in medical practice. Its medical use is totally experimental.[310] It can be introduced or delivered in interstate commerce only under investigational new drug approvals issued to qualified investigators by the FDA.[311] Neither would use of LSD be considered normal by most in the community. And though it may be fairly common for a person to give a tranquilizer to a friend or relative, it would not, except in certain groups, be common or considered normal to so distribute LSD.

In addition, dependence constitutes a significant problem with respect to the commonly used "medically" depressant and stimulant drugs. Existing knowledge of patterns of use of LSD is very skeletal. However, while there may well be some persons who are psychologically dependent on the drug,[312] LSD dependence currently appears to present much less of a problem than dependence on barbiturates, CNS depressants or amphetamines.

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[303] See Goldstein, "A proposal for a pre-charge conference" (preliminary draft) (May 16, 1966).

[304] Food, Drug, and Cosmetic Act, § 511(b), 21 U.S.C. § 360a(b).

[304a] See pp. 203–08 infra.

[305] Blum Report at 25. See also N.Y. C'ty Med. Soc'y Report, 22 N.Y. Medicine, No. 9, 3, 5–6 (May 5, 1966).

[306] *Id.*, at 7.

[307] See Blum Report at 22: Statement of Commissioner James L. Goddard of the FDA Before the Special Subcommittee on Juvenile Delinquency of the Senate Judiciary Committee, May 23, 1966, p. 3; N.Y. C'ty Med. Soc'y Supplementary Report, June 15, 1966, p. 2.

[308] Blum Report at 22; Goddard statement, note 307 supra, at 3.

[309] Blum Report at 25.

[310] See N.Y. C'ty Med. Soc'y Report, 22 N.Y. Medicine, No. 9, 3, 5 (May 5, 1966).

[311] Statement of Commissioner Goddard Before the Subcommittee on Executive Reorganization of the Senate Committee on Government Operations, May 24, 1966; see note 191 supra.

[312] See Ludwig and Levine, "Patterns of Hallucinogenic Drug Abuse." 191 J.A.M.A. 92, 95–96 (1965). As far as is known, dependence on LSD is psychological. It has not been shown that the use of LSD leads to physical dependence. See New York Times, May 23, 1966, p. 31, col. 7 (remarks of Commissioner James L. Goddard of the FDA).

Such information as is available emphasizes experimental and occasional weekend use rather than habitual use.[313]

Furthermore, while it may be that a large number of nondependent users of LSD are young, dissatisfied, disturbed, or otherwise present psychiatric problems, the law commonly treats such persons as punishable unless they come within general rules governing lack of criminal responsibility. To the extent that such rules apply to the generality of crimes they would be available to the LSD user charged with possession or use.

However, it is believed that criminal treatment, especially for the disturbed or dissatisfied, is warranted only when it is necessary for the protection of society or other individuals. When it is necessary such persons may be treated punitively so that they may be isolated and treated or rehabilitated if possible, so that society can voice its condemnation of their actions, and so that others may be deterred.

To what extent making simple possession or use of LSD a criminal offense would deter use by others, is of course, open to question. In all probability, it would deter some would-be users, but it would probably also encourage use by other persons.

While the verified dangers of LSD may, if they are shown to occur in a large number of cases, warrant an attempt to deter use by criminal sanctions against the user, it is submitted that it is inappropriate for either the Federal Government or the States to enact legislation prohibiting use or simple possession at this time. Such legislation should be deferred until there is a clearer showing that it is necessary. There are several reasons for this view.

First, it is not clear how often the dangerous effects of the drug occur. They may turn out to be either infrequent in relation to estimated total use (either in terms of number of users or doses), or they may turn out to be quite frequent; we do not know at this time. While it is unlikely that a completely accurate picture of the extent of illicit use will ever be available, with the passage of time we should have a better picture of the scope of the problems presented by the drug than we do at the present.

Second, although law enforcement against trafficking would probably be made easier by a simple possession or use offense, it is the belief of the Food and Drug Administration that it can control the traffic in LSD by enforcement of trafficking offenses, including the possession prohibition of the Federal law, and by seizure.[314] The law has been in effect for only a short time. The FDA is only now putting its men into the field. Many are still taking training courses. It should be given the opportunity to see if its expectations are warranted. It has indicated that if they are not, it will seek additional legislation. Moreover, while use of LSD is often a group activity [315] so that arrest of a group using the drug under a warrant or upon probable cause would probably be realistic, it would appear that enforcement would require undercover work culminating in a "buy" more often than in the case of other drugs. The drug is very difficult to detect and common articles may be impregnated with it, sometimes without trace. Thus, the utility of a simple possession or use offense might be limited.

Third, as in the case of the commonly used "medically" depressant and stimulant drugs, a simple possession offense would, to the extent that it is directed to later distribution, prohibit conduct which is ambiguous in relation to the evil at which it is aimed, while making irrelevant proof that the prohibited conduct was directed toward that evil.

Finally, Comissioner Goddard has pointed out that if possession were a crime, a principal avenue by which the FDA traces sources of LSD might be at least partially blocked, because some persons suffering adverse reactions might not seek medical assistance if they were subject to a possession charge.[316] This must be recognized as speculative. To the extent that it may be valid, however, it would be significant not only because of the leads furnished, but because persons suffering psychotic reactions from LSD should not be discouraged from seeking medical assistance.[317]

Even though it is believed that neither simple possession nor use should be prohibited at this time, it must be recognized that if the problem cannot be controlled through trafficking offenses and if adverse affects are found on a large scale, additional legislation may be in order in the future. Such legislation could take the form of a civil violation with a sanction other than interference with personal liberty. Again, a meaningful precharge conference would be desirable.

Furthermore, it is believed that unlike the situation with respect to the commonly used "medically" depressant and stimulant drugs, there is no reason to exempt from criminal liability possession for use of a member of the household or for administration to a household animal of LSD or any other controlled drug (whether or not it is a hallucinogen) which has no significant use in medical practice in the United States other than experimental use. The reasons which support the exemption for barbiturates, CNS depressants and amphetamines are not present in the case of such drugs. Congress should enact legislation making the exemption inapplicable to any controlled drug which the Secretary of Health, Education, and Welfare designates under such a standard. It is believed that this course should be followed because the FDA (acting for the Secretary) is better equipped to assess the extent of medical use of a drug than is Congress. A model State act could provide that the exemption would automatically be inapplicable to any drug so designated by the Secretary of Health, Education, and Welfare.

The fact that a person who possesses LSD or any other drug which does not have medical use outside of experimentation for use of a member of his household or for administration to a household animal may be an appropriate consideration for purposes of sentencing.[318] It is not believed that it should exempt from liability.

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[313] See Blum (ed.), Utopiates, passim (1964); Ludwig and Levine, note 312 supra, at 95.

[314] Statement by Commissioner Goddard of the FDA before the Subcommittee on Executive Reorganization of the Senate Committee on Government Operations, May 24, 1966, p. 12. LSD can be seized either under the provisions of the 1965 Federal amendments relating to administrative seizure of "depressant or stimulant drugs" (Food, Drug, and Cosmetic Act, §§ 304(a)(2), 702(e)(5), 21 U.S.C., §§ 334(a)(2), 372(e)(5)) or under provisions of the Food, Drug, and Cosmetic Act which permit the institution of seizure and condemnation proceedings against unapproved new drugs, which are introduced or delivered in interstate commerce. Sec. 304(a)(1), 26 U.S.C., § 334(a)(1).

[315] Blum (ed.), Utopiates, passim (1964); Ludwig and Levine, "Patterns of hallucinogenic drug abuse," 191 J.A.M.A. 92, 95 (1965).

[316] Testimony of Commissioner Goddard before the Subcommittee on Juvenile Delinquency of the Senate Judiciary Committee as reported in New York Times, May 24, 1966, p. 33.

[317] Persons suffering psychiatric reactions from LSD are usually treated in conventional psychiatric settings and in its report to the Commission, NIMH indicated that they "can probably be adequately handled" in these settings. NIMH, Report on Treatment of Narcotic Drug Addiction for the President's National Crime Commission at 32 (revised as of June 6, 1966). Where use has triggered psychotic reactions it would seem extremely doubtful that the criminal process would or should be invoked.

[318] Possession for such a purpose may often be deemed less culpable than possession for commercial distribution. On the other hand, there may be occasions where the circumstances of the offense aggravate it—as, for example, where possession is for administration to the possessor's young child.

The Other Hallucinogens (*Excluding Marihuana*)

In additon to marihuana which the Subcommittee on Narcotics Addiction of the Public Health Committee of the Medical Society of New York County has described as a "mild hallucinogen" [319] and LSD which the society has characterized as a "highly potent hallucinogen",[320] there are several other substances which the society characterizes as mild hallucinogens and several which it characterizes as "moderately potent hallucinogens." The former include nutmeg and morning glory seeds,[321] and the latter psilocybin, peyote, and mescaline.[322] Mescaline is the active principle in peyote.

Professor Blum reports that the use of hallucinogens appears to be increasing.[323] Thus, he states that "the use of other hallucinogens, peyote for example, has been fairly well confined to traditional (Indian) groups, but their use too is expanding to young urban people." [324] He further reports that mescaline psychosis has been verified.[325] Nevertheless, it is not believed that use of these hallucinogens warrants the same concern as does the use of the more potent LSD.[326]

It has been impossible, however, to study the problems posed by each of the hallucinogens in the time allotted, and it is recommended that if a simple possession or a use offense is to be created for any of them which the FDA has or should designate as a "depressant or stimulant drug" or for any other controlled drug, it should be after study of the effects of and problems presented by individual drugs. If after such study, it is concluded that a simple possession or use offense should be enacted, it should be created for individual drugs or drugs presenting common problems and should not automatically apply to every hallucinogen or class of hallucinogens. Moreover, while the FDA may appropriately furnish guidance to Congress in enacting such legislation, it is believed that the legislation should name particular drugs. Whether or not to punish for use or possession involves issues of such importance that the decision should be made by the legislature.

As in the case of LSD, it is believed that possession of other controlled hallucinogens which have no significant nonexperimental medical use in the United States for use of a member of the household or a household animal should not be exempted from criminal liability.

Religious Use

Peyote has for some time been used in religious ceremonies by the Native American Church. The House version of H.R. 2 recognized that use by providing "the Secretary shall not designate * * * [as a "depressant or stimulant drug"] * * * peyote (mescaline) but only insofar as its use is in connection with the ceremonies of a bona fide religious organization." [327] The provision was deleted by the Senate Labor Committee.[328] It was deleted because the committee deemed it advisable to avoid reference to particular drugs wherever possible.[329] The committee contemplated that peyote would be subject to control under the potential for abuse standard to the same extent as any other drug.[330]

In the debate in the House preceding its acceptance of the conference report on the bill, Representative Harris, chairman of the Commerce Committee, indicated that the FDA had informed him that it would permit use of peyote in connection with the sacraments of the Native American Church (an American Indian church) upon a showing that the church was a bona fide religious organization and used peyote in its sacraments.[331] He read to the House a letter from Commissioner Larrick of FDA taking this position.[332] The House then agreed to accept the conference report.[333]

Since the enactment of H.R. 2 the Secretary of Health, Education, and Welfare has issued a regulation permitting sacramental use by the church.[334] The regulation further provides that persons supplying peyote to the church are required to register and keep appropriate records of receipts and disbursements of it.[335] Other more recently formed groups using peyote or other hallucinogens have attempted to obtain exemption from the FDA but have to date not been successful.

Whether Congress or a State legislature may interfere with religious use of peyote or any other drug and whether a particular use or organization is religious are, of course, in the last analysis questions for the courts, because they present questions under the first amendment of the Federal Constitution as well as under most State constitutions. The U.S. Supreme Court has not yet passed on these questions. The Supreme Court of California, however, has held that a State statute prohibiting the unauthorized possession of peyote could not constitutionally be applied to possession for sacramental use by members of the Native American Church, because in light of the fact that peyote worked "no permanent deleterious injury to the Indian," the State had not demonstrated a compelling interest which justified interference with such use.[336] On the other hand, just recently, the Supreme Court of North Carolina rejected a first amendment claim advanced by a member of the Neo-American Church (in a prosecution for unauthorized possession of peyote and marihuana) on the ground that while the first amendment protects beliefs, it does not protect acts

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[319] N.Y. C'ty Med. Soc'y Report, 22 N.Y. Medicine, No. 9, 3, 4 (May 5, 1966).

[320] Ibid.

[321] Ibid. The society also characterizes airplane glue as a mild hallucinogen. Ibid.

[322] Ibid.

[323] Blum Report at 22.

[324] Ibid.

[325] Blum Report at 25.

[326] Cf., "In New York the use of [DMT], morning glory seeds, psilocybin, nutmeg, and mescaline is a minor problem * * *." N.Y. C'ty Med. Soc'y Report, 22 N.Y. Medicine, No. 9, 3, 5 (May 5, 1966).

[327] Printed in House Report at 35.

[328] S. Rept. No. 337, p. 3, 89th Cong., 1st Sess. (1965); 111 Congressional Record 14092, col. 1, 14094, col. 3 (Senate) (daily ed., June 23, 1965).

[329] S. Rept. No. 337, p. 3, 89th Cong., 1st Sess. (1965); 111 Congressional Record 14094, col. 3 (Remarks of Senator Yarborough) (daily ed., June 23, 1965).

[330] See the authorities cited in the preceding note.

[331] See 111 Congressional Record 15410, col. 2 and 3 (House) (daily ed., July 8, 1965).

[332] See 111 Congressional Record 15410, col. 3 (House) (daily ed., July 8, 1965).

[333] See 111 Congressional Record 15411, col. 1 (House) (daily ed. July 8, 1965).

[334] Federal Register, 21 CFR § 166.3(c)(3), Mar. 19, 1966, p. 4679, col. 3.

[335] Ibid.

[336] *People* v. *Woody*, 61 Calif. 2d 716, 40 Calif. Rptr. 69, 394 P. 2d 813, 818 (1964). The same result was reached in *Arizona* v. *Attakai*, Crim. No. 4098, Coconino C'ty (Ariz., July 26, 1960).

New Mexico exempts from its prohibition on sale and possession of peyote "the possession, sale or gift of peyote for religious sacramental purposes by any bona fide religious organization incorporated under the laws" of the State. N. Mex. Stat. Ann., § 54-5-16 (1962). A similar exemption is contained in Montana. Mont. Rev. Code, § 94-35-123 (Supp. 1965).

In the *Woody* case the court stressed "* * * as the Attorney General * * * admits, the opinion of scientists and other experts is 'that peyote * * * works no permanent deleterious injury to the Indian * * *.' " 394 P. 2d at 818. It also stated that where a claim of religious use is invoked the trier of fact is to confine its inquiry to "whether the defendants' belief in Peyotism is honest and in good faith * * * or whether he seeks to wear the mantle of religious immunity merely as a cloak for illegal activities." 394 P. 2d at 820-21.

In *In re Grady*, 61 Calif. 2d 887, 39 Calif. Rptr. 912, 394 P. 2d 728 (1964), a habeas corpus proceeding decided on the same day as Woody and involving a "peyote teacher" who was not a member of the Native American Church, it read Woody broadly: "We held in *people* v. *Woody* that the state may not prohibit the use of peyote in connection with bona fide practice of a religious belief" (394 P. 2d at 729). In Grady the court remanded the case for a hearing as to the sincerity of the petitioner's belief, the scope of inquiry to be that stated in *Woody*.

"which constitute threats to the public safety, morals, peace, and order." [337]

It is submitted that the constitutional problems presented by claims of religious use should be recognized in a forthright manner by a statutory provision to the effect that nothing in the Food, Drug, and Cosmetic Act should be deemed to interfere with any right protected by the free exercise clause of the first amendment to the Federal Constitution. Such a provision would state a constitutional standard.

While no recommendation is made, Congress may also desire to provide, in effect, that nothing in the act shall be deemed to interfere with manufacture, disposition, possession, or use of a "depressant or stimulant drug" protected by a provision of an applicable State constitution which in substance guarantees the free exercise of religion. Such a provision would permit religious use of a drug when it is protected by a State constitution even if it would not be protected by the Federal Constitution; it would state a standard measured by what is permissible under the State constitution. In effect, it would show a congressional intent to respect a State determination that a particular religious use is protected within the State by the State constitution. No recommendation is made as to the wisdom of such a provision. To what extent Congress desires to respect State determinations in this area is a question it must answer.

A model State act should also recognize the constitutional problem by containing a complementary provision to the effect that nothing in the act should be deemed to interfere with any provision of the State constitution which in substance guarantees the free exercise of religion or with any right protected by the free exercise clause of the first amendment to the United States Constitution. Such a provision would also state a constitutional standard.

UNAUTHORIZED MANUFACTURE

It is recommended that unauthorized manufacture should not be a criminal offense unless it is done with a purpose to sell or otherwise dispose of a controlled drug. Illicit manufacturers usually manufacture "depressant or stimulant drugs" to distribute them. However, some controlled drugs may be made on a small scale for personal use. Thus, it is possible that some individuals may be making LSD solely for their own use. Many of the same reasons which support the exemption of persons who without authorization possess controlled drugs solely for their own use from criminal liability also support their exemption from criminal liability for unauthorized manufacture. Even more than possession, unauthorized manufacture is an offense preparatory to distribution. If the manufacture is not for distribution and if the user is not to be punished for his use, the manufacturer who manufactures for his own use should not be punished either. The mere fact that the user makes the drug himself instead of obtaining it in some other fashion does not stamp him as a more dangerous person. To prove that manufacture was for the purpose of sale or other disposition should not ordinarily be a difficult matter. Law enforcement agencies often trace illicit producers through leads furnished by persons who distribute for them or whom these producers otherwise supply. "Simple" unauthorized manufacture, however, may be appropriately treated as a civil violation.

It is not recommended that manufacturing a controlled drug for the use of a member of the manufacturer's household or for administration to an animal owned by him or a member of his household should be exempted from the prohibition on unlawful manufacture. Such conduct cannot be justified as relatively normal or common.

MISREPRESENTATION AND DECEPTION PROVISIONS

The Uniform Narcotic Drug Act [338] and some State statutes dealing with depressant and stimulant drugs [339] make various types of misrepresentations and deceptions in obtaining controlled drugs, crimes. Such provisions are found in the Model State Drug Abuse Control Act [340] and the Model State Barbiturate Act.[341] There are no such provisions in the 1965 Federal amendments. Misrepresentation and deception provisions vary, but the Model State Drug Abuse Act provisions are fairly illustrative. It prohibits obtaining or attempting to obtain a controlled drug by (1) fraud, deceit, misrepresentation or subterfuge, (2) falsely assuming the title of or representing one's self to be a person authorized to possess a controlled drug, (3) use of a forged or altered prescription, (4) using a false name or false address on a prescription.[342]

Conduct which would violate such provisions would seem to be more common in the case of commonly available "medically" depressant or stimulant drugs than with respect to hallucinogens such as LSD or marihuana. There is virtually no legitimate traffic in the latter drugs, and misrepresentations and deceptions divert drugs from legitimate channels of trade. Misrepresentation and deception offenses are from one point of view user offenses in that persons commonly commit them to obtain drugs for their own use. Thus, forgeries and alterations of prescriptions are methods by which users obtain drugs for personal use from legitimate sources without resorting to illicit markets.[343] Obtaining supplies of controlled drugs for personal use by conduct which would violate such provisions may be a relatively common method of obtaining "medically" depressant or stimulant drugs.[344] A person may go to several physicians at the same time for an alleged condition and receive a prescription for a restricted drug from each of them without disclosing that he has prescriptions from the others,[345] or a person may raise the quantity on a prescription,[346] or even steal a prescription pad to write prescriptions for himself.[347] The author has been told by physicians and law enforcement officers that these devices are often resorted to by middle-class abusers.

However, misrepresentation and deception provisions may also be violated in obtaining drugs for distribution. A person may steal a pad of prescriptions, forge the prescriptions, and sell some or all of the drugs received. Or a person may represent himself to be a jobber or wholesaler of drugs and via this representation purchase drugs for sale in illicit markets.[348] While success in this kind of endeavor would presumably be more difficult under the 1965 amendments than it was before, it is not impossible; endeavors of this kind probably will continue[349] even though upon a reduced scale.[350]

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[337] *State v. Bullard,* 267 N.C. 599, 148 S.E. 2d 565, 568–69 (1966). The court also questioned but did not pass on the sincerity of the defendant's religious belief. Id., at 568.

[338] Uniform Narcotic Drug Act, § 17. Misrepresentation and deception provisions are contained in the pending New Jersey legislation dealing with dangerous drugs. N.J. Assembly No. 548, § 7 (introduced Mar. 14, 1966).

[339] E.g., Fla. Stat. Ann. § 404.02(8) (1960); Ill. Rev. Stat. ch. 111½ §§ 445 445.1 (1966); New York Public Health Law § 3391.

[340] Model State Drug Abuse Control Act, § 7(d).

[341] Model State Barbiturate Act, § 2(8).

[342] Model State Drug Abuse Control Act, § 7(d).

[343] See Pumpian, "The role of the state board of pharmacy," 2 J. Nat'l Dist. Att'ys Ass'n 13 (1966) (hereinafter "Pumpian").

[344] Cf., Ibid.

[345] Pumpian at 14.

[346] Pumpian at 13.

[347] Cf., Pumpian at 13.

Despite the fact that "medically" depressant and stimulant drugs may often be obtained by conduct which may violate one or another of so-called misrepresentation and deception provisions and that in a sense such provisions might be viewed as punishing the user for his use, it is recommended that it be made a prohibited act under the Federal Food, Drug, and Cosmetic Act for a person to obtain or attempt to obtain any controlled drug, with a purpose to sell or otherwise dispose of the drug sought or obtained, by knowing misrepresentation, deception, or subterfuge, from any person or firm that he believes is a manufacturer or wholesaler of such a drug or from any person whom he believes is an employee of such a manufacturer or wholesaler, and who in fact is a manufacturer or wholesaler of a controlled drug registered as such under the Federal act or an employee of such a registered manufacturer or wholesaler. Under such a provision the Government would not be required to prove that the actor believed that the person or firm against whom the deception was directed, or his employer, was registered as a manufacturer or wholesaler under the Food, Drug, and Cosmetic Act, but it would be required to prove that such person or firm was in fact a manufacturer or wholesaler of a controlled drug registered as such under the Federal act or an employee of such a registered manufacturer or wholesaler. The reason for requiring the Government to prove that the victim or the victim's employer was registered under the Federal act is to make sure that the provision does not reach the situation where a person practices deception against an illegitimate distributor. Deception offenses—as will shortly appear—are primarily directed at protecting the integrity of legitimate channels of distribution, and it is not believed that there is any significant interest in promoting honor among thieves in this situation.

In addition, it is recommended that a model State act include provisions which prohibit a person from obtaining or attempting to obtain a controlled drug by: (1) Knowing misrepresentation, deception, or subterfuge (*a*) from any person or firm (i) that he believes uses such a drug in research, teaching, or chemical analysis or from any person whom he believes is an employee of such a person or firm, and (ii) who in fact is authorized by law to dispose of such a drug or is an employee of a person or firm authorized by law to dispose of such a drug, or (*b*) from any person or firm that (i) he believes is a manufacturer or wholesaler of such a drug, a warehouse, a contract or common carrier, a pharmacist or pharmacy, a practitioner, or a hospital, clinic, or public health agency, or from any person whom he believes is an employee of any of the foregoing, and (ii) who in fact is authorized by law to dispose of such a drug or is an employee of a person or firm authorized by law to dispose of such a drug; (2) use of a knowingly forged or altered prescription; (3) use of a knowingly false name or address on a prescription.[351]

Under (1) of the foregoing provisions the State would be required to prove that the victim of the deception or his employer was actually authorized by law to dispose of a controlled drug. It would also be required to prove that the defendant believed the victim or his employer was a type of person authorized by law to dispose of a controlled drug—as a physician or wholesaler, but it would not be required to prove that the defendant believed that the victim or his employer was registered or licensed as the case may be (e.g., that the victim was a licensed physician or registered wholesaler). The reason for requiring the State to prove that the victim or his employer was in fact a person authorized to possess a controlled drug, is, again, to avoid reaching deceptions against illicit distributors.

The mere fact that misrepresentation and deception provisions may frequently be violated in obtaining drugs for personal use does not necessarily mean that the user should not be punished for deception even if he is not to be punished for obtaining from an illicit source. Should the user obtain drugs or funds to buy them by larceny or robbery he would be amenable to punishment for the theft or robbery. Even though the larceny or robbery may have been inevitable for the dependent user because of his need for the drugs, where the drugs are so obtained there are interests in addition to those in preventing the simple unauthorized use or distribution of drugs that the law wishes to vindicate. In the case of larceny there is an interest in protecting against interference with the enjoyment of property by stealthful or trespassory takings. In the case of robbery there is an interest in protecting against such interferences by trespassory takings which are accompanied by personal harm or excite a fear of personal harm. In the case of legislation specifically prohibiting larceny or robbery of prescription drugs or dangerous drugs from persons authorized to distribute them there would also be an interest in protecting the integrity of legitimate distribution from diversions accomplished by these means.

Legislation prohibiting deceptive practices in obtaining dangerous drugs is also directed at protecting an interest in addition to the interests in preventing simple unauthorized use or distribution of these drugs. There is an interest in preserving the integrity of legitimate channels of trade in such drugs by preventing those channels from being used unwittingly to supply them for illegitimate purposes. The law desires to have legitimate distributors act in accord with a system it has created or recognized without having that system undermined by conduct which causes them to unknowingly distribute drugs that they would not knowingly distribute. The basic interest is in protecting legitimate channels of trade from such threats.[352] The problem is whether this interest is outweighed by others, such as an interest in exempting the user from punishment for conduct incidental to his use, or by the possible effects such provisions might have on the conduct of persons who would violate them.

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[348] Cf., the interesting account of McMullen's Services in testimony of Jay L. McMullen, Hearings at 271–287 (1965). Before the enactment of the 1965 amendments, in order to determine how difficult it was to secure "depressant and stimulant drugs" from legitimate drug manufacturers, a team from CBS news set itself up in business as "McMullen's Services," printed a letterhead which merely gave its name and said "Export-Import" and, using this letterhead, ordered large quantities of "medically depressant and stimulant drugs" from a number of manufacturers of these drugs. Although a number of manufacturers refused to deal with it, the "firm" was, merely on the basis of requests and orders on this letterhead, able to secure large quantities of drugs from others.

[349] Under the 1965 Federal amendments deceptive conduct directed to obtaining a controlled drug cannot be reached at all if the actor does not succeed in obtaining the drug. If he does succeed, he can, of course, be held for (*a*) a violation of the possession prohibition if he obtained a quantity sufficient to prove that possession was for disposition or if there is independent evidence that possession was for disposition and (*b*) if he disposed of the drug, for disposition itself. Under a State dangerous drug law which does not contain deception provisions such as those under discussion, again the actor cannot be held if he does not succeed in obtaining the drug. If simple possession is prohibited, he may be held for that crime even if there is no evidence that possession was for disposition.

Some misrepresentations whereby controlled drugs are actually obtained might support conviction for obtaining property by false pretenses in a jurisdiction where a misrepresentation that does not result in a tangible loss may be the subject of that crime. Where, however, a misrepresentation resulting in a tangible loss is required, no conviction would seem possible. Compare, *e.g.*, the majority and dissenting opinions in *Nelson* v. *United States*, 227 F. 2d 21 (D.C. Cir. 1955). Where the actor does not succeed in obtaining drugs, liability for attempted false pretenses would similarly seem to depend on whether a misrepresentation not calculated to result in a tangible loss may support the charge.

[350] Of course, a person can also engage in such endeavors to obtain drugs for personal use.

[351] Both Federal and State provisions should expressly except from their operation Federal and State officers and employees of State subdivisions while acting in the course of their official duties. It may also be desirable to except, as the Model Drug Abuse Control Act (§ 7(d)) does, drug manufacturers and their agents and employees, when they are engaged in authorized investigative activities directed toward safeguarding trademarks.

To the extent that misrepresentation and deception provisions are enforced against users it could be that some persons who obtain controlled drugs by deception of legitimate sources will turn to illegitimate sources. Depending on one's point of view this could be regarded as either a fortunate or unfortunate development.[353] However, it is also possible that some nondependent users resorting to deception will be unable or unwilling to make contacts with illegitimate sources and will cease use. Other users, perhaps most, will just continue to obtain by deception.

Other things aside, it can be argued that misrepresentation and deception provisions are undesirable, because they may make a user a criminal for conduct that is no worse than the conduct of the user who buys a drug from a peddler and that does not necessarily indicate that the offender is a more dangerous person. Nevertheless, it is believed that the interest in protecting the integrity of legitimate channels of trade in controlled drugs from such conduct is worthy of protection. Consequently, it is recommended that a model State act contain provisions directed against misrepresentation and deception. The fact that the offender has engaged in misrepresentation or deception to obtain drugs for his own use may be an appropriate consideration in grading offenses [354] or in sentencing, but it should not in itself exempt him from liability unless he is found irresponsible.

The Federal deception offense proposed herein is intended to enable the Federal Government to reach persons who use techniques of deception in situations where such techniques are most likely to result in the diversion of large amounts of drugs. It would appear that most attempts to obtain large amounts of drugs by misrepresentation and deception would involve conduct directed against manufacturers or wholesalers.

It is believed that the Federal Government has a particular interest in large-scale diversions. This interest is underscored by the fact that only manufacturers and wholesalers must register under the Federal act. Small diversions from manufacturers and wholesalers may be reached under the misrepresentation and deception provisions proposed for a model State act. The limitation of the proposed Federal provision to misrepresentations and deceptions for sale or other disposition is not based upon the view that the user should be exempted because he is a user, but upon the view that the Federal Government's particular interest is in preventing misrepresentation and deceptions likely to result in large-scale diversions.

While an offender may sometimes obtain or attempt to obtain fairly large quantities of drugs by deceptions directed against authorized persons whom he does not believe to be wholesalers or manufacturers or by deceptions involving prescriptions, it would seem that such deceptions would usually involve small quantities intended for personal use. Since the Federal Government is peculiarly concerned with illegal trafficking at high levels of distribution and involving large-scale diversions, and the States are most concerned with trafficking at lower levels, the creation of State offenses for such conduct would appear to be sufficient. Further, insofar as deceptions involve misuse of prescriptions or are practiced against physicians, hospitals, or retail pharmacists they involve an area in which State interest has historically been dominant. To the extent that the States are to take the lead in enforcement involving physicians, hospitals, and pharmacists, it would seem particularly appropriate that deceptions against them be dealt with by State law. However, if State efforts should prove ineffective or the focus of Federal activity and enforcement effort should shift, the creation of such offenses at the Federal level might be considered.

BASIS OF LIABILITY, GRADING AND PENALTIES

Under existing Federal law the penalties provided for violations of the provisions of the Food, Drug, and Cosmetic Act involving "depressant or stimulant drugs" are with one exception the penalties prescribed for violations of other provisions of the act. Sales and other dispositions of controlled drugs to minors are given special treatment. There are no mandatory minimum penalties, and probation, suspended sentence, parole, and youthful-offender treatment are available to convicted violators. Commissioner Larrick of the FDA opposed mandatory penalties during his testimony on H. R. 2 before the House Commerce Committee.[355]

The basic offense under the act is a misdemeanor which is punishable by imprisonment for not more than 1 year and a maximum fine of $1,000. Subsequent offenses are punishable by a maximum of 3 years imprisonment and a fine of not more than $10,000. These penalties are applicable to such offenses as failure to register; [356] failure to prepare, obtain or keep complete and accurate records; refusal to permit access to or copying of records; and refusal to permit entry or inspection, as well as to unlawful manufacture, disposition, and possession, and filling or refilling of a prescription in violation of the limitations earlier discussed.

In addition to these offenses there are aggravated offenses. Violations with intent to defraud or mislead are punishable by not more than 3 years' imprisonment and a fine of not more than $10,000. This mental element which aggravates almost all offenses under the act apparently was designed for aggravated offenses of misbranding and adulteration and appears relevant to such conduct. However, it is questionable to what extent it states either a precise or relevant mental element in connection with offenses related to "depressant or stimulant drugs."

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[352] Cf., 18 U.S.C., § 1001, which prohibits the making of false statements "in any matter within the jurisdiction of any department or agency of the United States." Like the offenses presently under discussion this offense is designed to protect the integrity of a system or procedure the law has created.

[353] Some might think it of the utmost importance that there be no leakage from legitimate channels, even if the traffic moves to illegitimate channels, possibly because this might keep those who would not resort to illicit channels away from unauthorized use. Others might feel that it is undesirable to force users into illicit channels where they might be exposed to other drugs and to criminal activities.

[354] See text ff. notes 379 and 422, *infra*.

[355] Testimony of Commissioner George P. Larrick, Hearings at 359.

[356] Registration is required of manufacturers of all drugs and not just manufacturers of "depressant or stimulant drugs." Food, Drug, and Cosmetic Act, § 510, 21 U.S.C., § 360(b).

Dispositions by persons who are 18 years of age or older to persons under 21 are punishable by a maximum of 2 years' imprisonment and a maximum fine of $5,000. Subsequent offenses involving dispositions to minors are punishable by not more than 6 years imprisonment and a maximum fine of $15,000.

A Civil Violation

Decisions relating to penalties for offenses and to the grading of offenses are to some extent dependent upon decisions as to the mental element or elements that must accompany prohibited conduct. A greater penalty is probably appropriate for a knowing sale of a controlled drug than for a sale made by an actor who merely is negligent as to whether the substance he sells is or is not a controlled drug and a fortiori than for a sale by an actor who is both unaware that the drug he sells is a controlled drug and who is not negligent in his lack of awareness.

The 1965 Drug Abuse Control Amendments do not specify what mental element is required to convict the defendant of the misdemeanors it creates. Nor does the legislative history of those amendments advert to the subject. Before the enactment of these "depressant and stimulant drug" provisions, other provisions of the Food, Drug, and Cosmetic Act were interpreted to impose strict liability.[357] That is, they have been interpreted to dispense with the necessity of proving purpose, knowledge, or recklessness—the traditional common law requirements of culpability—or even negligence. [358] In addition, in prosecutions for violations of section 2 of the Harrison Narcotics Act which prohibits the disposition of a narcotic drug except in pursuance of a written order issued by the Treasury Department the defendant may be convicted even if he did not and could not reasonably have been expected to know that the drug he sold was a narcotic drug.[359] On the other hand, the Revised Penal Law of New York which is scheduled to go into effect on September 1, 1967, requires that all narcotic and dangerous drug offenses be committed "knowingly." [360] The Model Penal Code not only rejects strict liability for offenses under the Code but for criminal offenses created under other statutes as well.[361]

The Food, Drug, and Cosmetic Act should be amended to clarify the mental element necessary to convict of the basic offense. Criminality under it should not be based on strict liability. Strict liability offenses have been subjected to widespread criticism, because dispensing with proof of purpose, knowledge, recklessness, and even negligence they permit the punishment of persons who are not blameworthy, who do not require reeducation, and who could not have been deterred.[362] The comments to the Model Penal Code state:

> The liabilities involved are indefensible in principle, unless reduced to terms that insulate conviction from the type of moral condemnation that is and ought to be implicit when a sentence of imprisonment may be imposed. In the absence of minimal culpability, the law has neither a deterrent nor corrective nor an incapacitative function to perform.[363]

Strict liability is usually supported on the ground that it is necessary to effective law enforcement, because if the prosecution is required to prove either a traditonal mental element or negligence some guilty persons would go unpunished. In rejecting strict liability as a basis for criminal liability but adopting the principle that strict liability might support a charge of a civil violation sanctioned by a monetary penalty, forfeiture, or another civil penalty, the reporters of the Model Penal Code both recognized this argument and rejected it as insufficient to warrant the imposition of criminal sanctions.

> It has been argued, and the argument undoubtedly will be repeated, that absolute liability is necessary for enforcement in a number of the areas where it obtains. But if practical enforcement can not undertake to litigate the culpability of alleged deviation from legal requirements, we do not see how the enforcers rightly can demand the use of penal sanctions for the purpose. Crime does and should mean condemnation and no court should have to pass that judgment unless it can declare that the defendant's act was wrong. This is too fundamental to be compromised. The law goes far enough if it permits the imposition of a monetary penalty in cases where strict liability has been imposed.[364]

While it might be sought to justify criminality based on strict liability by claiming that such liability helps to hold those subject to it to a high standard of care, it is hard to see how such offenses induce compliance or deter violations by those who could not have been expected to avoid in engaging in the conduct prohibited, because they could not reasonably have been expected to be aware of the facts giving rise to liability. The criminal sanction is usually the harshest governmental sanction known to our society, often involving loss of liberty and always moral condemnation. This saction should not be available without regard to the defendant's mental state or without regard to whether or not he was negligent. While the Food, Drug, and Cosmetic Act contains a provision stating that the Secretary of Health, Education, and Welfare is not under a duty to report minor violations when he believes that the public interest will be adequately served by written notice or warning,[365] it is not believed that the decision whether or not to prosecute those who are neither negligent nor otherwise culpable should be left to administrative or prosecutor discretion.

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[357] *United States* v. *Weisenfeld Warehouse Co.*, 376 U.S. 86 (1964); *United States* v. *Dotterweich*, 320 U.S. 277 (1943) (both strict and vicarious liability); *Palmer* v. *United States*, 340 F. 2d 48 (5th Cir. 1964) (trafficking in amphetamines: conviction based on violation of different provisions of the act).

[358] "Negligence" is used herein in the sense that it is used in the Model Penal Code, § 2.02(2)(d) of the Code provides:

> A person acts negligently with respect to a material element of an offense when he should be aware of a substantial and unjustifiable risk that the material element exists or will result from his conduct. The risk must be of such a nature and degree that the actor's failure to perceive it, considering the nature and purpose of his conduct and the circumstances known to him, involves a gross deviation from the standard of care that a reasonable person would observe in the actor's situation.

Such negligence has been referred to as unconscious or inadvertent negligence to distinguish it from the situation where the actor disregards a substantial and unjustifiable risk of which he is conscious or aware. The latter is usually called recklessness (See Model Penal Code, § 2.02(2)(c) (1962)), but has also been referred to as conscious or advertent negligence. It is a traditional requirement of culpability. Even inadvertent negligence has been used as a basis of liability for certain common law crimes. See *Commonwealth* v. *Pierce*, 138 Mass. 165 (1884) (Holmes, J.) (manslaughter); *Director of Public Prosecutions* v. *Smith, House of Lords*, 1960 [1960] 3 Weekly L.R. 545 (negligent murder).

[359] *United States* v. *Balint*, 258 U.S. 250 (1922). See also *United States* v. *Behrman*, 258 U.S. 280 (1922).

[360] New York Revised Penal Law, §§ 220.05–.45.

[361] Model Penal Code, § 2.05(2). Of course, the code does not purport to bind future legislatures, but even as to subsequent statutes it requires that a legislative purpose to impose strict liability must "plainly" appear. Sec. 2.05(1)(b).

[362] See generally, e.g., Hall General Principles of Criminal Law 325–359 (2d ed. 1960); Williams, Criminal Law: The General Part §§ 75–90 (2d ed. 1961); Gausewitz, "Reclassification of certain offenses as civil instead of criminal," 12 Wis. L. Rev. 365 (1937); Henry M. Hart, "The aims of the criminal law," 23 Law and Contemp. Prob. 401 (1958); Mueller, "Mens rea and the law without it," 58 W. Va. L. Rev. 34 (1955); Sayre, "Public welfare offenses," 33 Colum. L. Rev. 55 (1933); Wechsler, "The American Law Institute: some observations on its model penal code," 42 A.B.A.J. 321 (1956).

[363] Comments to Model Penal Code, § 2.05, Tent. Draft No. 4, 140 (1955).

[364] Comments to Model Penal Code, § 2.05, Tent. Draft No. 4, 140 (1955).

[365] Food, Drug, and Cosmetic Act, § 306, 21 U.S.C., § 336.

In light of the foregoing it is recommended that if the Government desires to avoid litigating the state of mind or degree of care of the actor in prosecutions involving violations of provisions of the Food, Drug, and Cosmetic Act involving "depressant or stimulant drugs," the act should be amended to create civil violations punishable by fine, forfeiture, or other civil sanction.[366]

Even if the Commission should determine that the manufacturing, possession, and disposition offenses and the offense involving filling or refilling of a prescription should be strict liability offenses, it does not necessarily follow that the offenses of failure to register or keep proper records and refusal to permit inspection or access to records should also be based on strict liability. The creation of a civil violation would be particularly appropriate for such derelictions, because of the relationship between these offenses and the ultimate evil of distribution is more remote than is the relationship between unauthorized distribution and unauthorized manufacturing, possession, disposition, and prescription filling and refilling in that the mere commission of these offenses does not necessarily create a likelihood that controlled drugs will move outside of legitimate channels.

Moreover, even if the creation of a civil violation for innocent derelictions should be rejected, the maximum penalty for such dereliction should be reduced from the current 1 year. Sixty days would seem a reasonable maximum. Under Federal law an offender sentenced to more than 180 days of confinement is eligible for parole at the end of one-third of the sentence actually imposed.[367] The maximum duration of imprisonment possible for a Federal strict liability offense should in no event exceed the minimum period after which parole eligibility begins for a Federal prisoner. Such a reduction in the maximum penalty might again be deemed appropriate for failure to register or keep proper records and refusals to permit inspection or access to records even if it is not deemed appropriate for the offenses more closely related to distribution. In no event should the maximum penalty for a strict liability offense be increased beyond the year which is currently the maximum penalty for unaggravated offenses.

Criminal Liability for Negligence

It is recommended that negligence should be the basis of liability as to all elements of every misdemeanor under the act[368] relating to "depressant or stimulant drugs," except that in the case of unauthorized possession the subjective purpose of the possessor would have to be one which the act prohibits,[369] and, if the Commission adopts the recommendation made herein with respect to manufacture, a purpose to sell or otherwise dispose would be required for the manufacturing offense. Negligence should be required to avoid subjecting to criminal liability the person who is reasonably ignorant or mistaken as to a matter of fact and, within limits, the person who reasonably believes that his conduct does not constitute an offense. Ignorance or mistake as to such matters of fact as whether the drug involved in a transaction is a controlled drug probably occurs rather infrequently. However, such situations are certainly not beyond the realm of the possible, and persons who are reasonably unaware of facts upon which criminal liability depends should not be subjected to it. The problem may be handled by making negligence as to matters of fact an element of the offense or by making reasonable ignorance or mistake as to such matters a defense.[370] A reasonable belief that conduct does not constitute an offense might occur with respect to any of the "depressant and stimulant drug" offenses under the act, but is probably most likely to occur with respect to the offenses involving registration, records, and entry and inspection. Thus, a manufacturer or wholesaler might be reasonably mistaken as to the adequacy of his records or as to an inspector's authority to inspect in a particular situation. A belief that conduct does not constitute an offense should avoid liability to the limited extent that it is recognized as a defense under section 2.04(3) of the Model Penal Code. That section provides:

> (3) A belief that conduct does not legally constitute an offense is a defense to a prosecution for that offense based upon such conduct when:
>
> (*a*) the statute or other enactment defining the offense is not known to the author and has not been published or otherwise reasonably made available prior to the conduct alleged; or
>
> (*b*) he acts in reasonable reliance upon an official statement of the law, afterward determined to be invalid or erroneous, contained in (i) a statute or other enactment; (ii) a judicial decision, opinion or judgment; (iii) an administrative order or grant of permission; or (iv) an official interpretation of the public officer or body charged by law with responsibility for the interpretation, administration or enforcement of the law defining the offense.

This could be accomplished by treating the absence of any of the foregoing circumstances as an element of the offense or by treating a belief under any of these circumstances as a defense.[371]

Moreover, normal rules of justification should apply. Thus, a pharmacist should be able to defend against a charge of refilling a prescription more than 6 months after it was issued on the ground that he reasonably believed immediate action on his part was necessary to save the life of the person for whom the prescription was issued. The defense should not be available where the actor was negligent in his belief or in acquiring or failing to acquire any knowledge or belief which is material to the justification.[372]

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[366] A proposal that a civil fine be used to reach innocent violators of the Food, Drug, and Cosmetic Act was made in "Developments in the law: the Federal Food, Drug, and Cosmetic Act," 67 Harv. L. Rev. 632, 696 (1954).

[367] 18 U.S.C., § 4202.

[368] Criminal liability based on negligence for violations of the Food, Drug, and Cosmetic Act is suggested in "Developments in the law: the Federal Food, Drug, and Cosmetic Act," 67 Harv. L. Rev. 632, 696 (1954).

[369] E.g., in effect, the Government would have to prove that the possession was for sale or disposition to a person other than a member of the possessor's household or was not for administration to an animal owned by the possessor or a member of his household, but negligence as to whether the drug possessed was a controlled drug would be sufficient.

[370] It is not permissible to create a presumption in a criminal statute assuring that upon the introduction of evidence of a basic fact by the prosecution a given issue will be submitted to the jury even if the defendant offers evidence on the issue, unless there is a rational connection between the fact proved and the facts presumed. *United States* v. *Romano*, 382 U.S. 136 (1965); *United States* v. *Gainey*, 380 U.S. 63 (1965) (dictum); *Tot* v. *United States*, 319 U.S. 463 (1943). It is possible that it is also improper for a criminal statute to treat an issue as an affirmative defense and, thus, relieve the prosecution of the burden of producing evidence of it in the first instance, unless there is such a connection between the ultimate facts the Government must prove in the first instance and the matter of defense. Compare *Tot* v. *United States*, supra, at 469 (dictum), with Comments to Model Penal Code, § 1.13 (now § 1.12), Tent. Draft No. 4, 111 (1955).

[371] See the preceding note.

[372] Cf., Model Penal Code, § 3.09(2) (1962).

These negligent offenses should be misdemeanors. While a maximum penalty of 1 year's imprisonment and a $1,000 fine, which is the maximum penalty for the basic offense under the Federal amendments, would not be inappropriate, a lesser maximum penalty such as 6 months would not be inappropriate either.

It is believed that negligence is an appropriate basis upon which to rest the punishment of conduct relating to "depressant or stimulant drugs." Whether negligent conduct involves culpability sufficient to be the basis of criminal liability and whether punishment for negligence is efficacious have been debated only slightly less than the similar questions raised regarding strict liability.[373] It is believed, however, that the criminal law may appropriately be directed against risk-creation and that a gross deviation from a norm may be blameworthy even if the actor fails to perceive risk, and, therefore, that negligence can furnish an appropriate basis for criminal liability. In addition, while the efficacy of punishment for negligence may be debatable, it is by no means clear that liability based on an objective standard can never serve to raise standards of care. The reporters of the Model Penal Code have stated: [374]

> Knowledge that conviction and sentence, not to speak of punishment, may follow conduct that inadvertently creates improper risk supplies men with an additional motive to take care before acting, to use their faculties and draw on their experience in gauging the potentialities of contemplated conduct. To some extent, at least, this motive may promote awareness and thus be effective as a measure of control. Certainly legislators act on this assumption in a host of situations and it seems to us dogmatic to assert that they are wholly wrong. Accordingly, we think that negligence, as here defined, cannot be wholly rejected as a ground of culpability which may suffice for purposes of penal law, though we agree that it should not be generally deemed sufficient in the definition of specific crimes, and that it often will be right to differentiate such conduct for the purpose of sentence.

Thus, the Model Penal Code recognizes negligence as an appropriate, though an unusual basis of criminal liability.

The above is not to say that a failure to perceive risk is as blameworthy as conduct in disregard of a risk actually perceived or as knowing or purposeful conduct. Generally it is not, and in some circumstances this may warrant a decision not to impose criminal liability for negligence and in others, grading distinctions. Liability for negligence should not be imposed indiscriminately. Such liability would seem particularly appropriate in situations, among others, where the likely alternative to it is strict liability,[375] where the law especially desires to raise standards of care and where proof of a traditional mental element is peculiarly difficult. Most regulatory schemes present the first two situations, and arguably may—depending on the circumstances—present the third also. The regulation of production and distribution of "depressant and stimulant drugs" is no exception. To the extent the argument that it is more difficult to prove a traditional mental element in the case of so-called regulatory offenses than in the case of traditional common law felonies has validity, and to the extent it is desired to raise standards of care in areas subject to regulation, liability for negligence for so-called regulatory crimes may be an acceptable half-way house [376] between strict liability and a crime which requires proof of a traditional mental element. Proof of departure from an objective standard should be easier than proof of a subjective state of mind; at least the trier of fact is not required to find that defendant's actual state of mind was culpable in order to convict. At the same time a defendant who could not reasonably be expected to perceive a risk and who, therefore, is in no sense blameworthy, could escape liability.

Aggravated Offenses

It was earlier suggested that the intent to defraud or mislead which aggravates an offense under the Federal act, while an appropriate basis of aggravation for such offense as misbranding and adulteration might be inappropriate as a basis of aggravation for offenses relating to "depressant or stimulant drugs." It is difficult to know what intent to defraud or mislead means in connection with such offenses. It is believed that the following aggravated offenses are more appropriate to prohibited conduct relating to "depressant or stimulant drugs."

Offenses Involving Registration, Records, and Entry and Inspection. It is recommended that failure to register; failure to prepare, obtain, or keep complete and accurate records; refusal to permit authorized access to or copying of records; and refusal to permit authorized entry or inspection, should constitute felonies if done with an awareness that the failure or refusal is unlawful and with (*a*) a purpose to manufacture or dispose or to further the manufacture or disposition of a "depressant or stimulant drug" otherwise than as authorized by the act and with an awareness of the unlawfulness of the manufacture or disposition intended or to be furthered, or (*b*) an awareness that the failure or refusal will further the manufacture or disposition of a "depressant or stimulant drug" otherwise than as authorized by the act and with an awareness of the unlawfulness of the manufacture or disposition to be furthered. Normal rules of justification would apply. The mental elements described, relating the defendant's conduct to an ultimate end of distribution, would seem appropriate to aggravate offenses that are designed to enforce regulatory provisions intended to make diversions from legitimate channels more difficult. In addition, the prohibitions under discussion are primarily directed to those involved in legitimate channels of trade. Legitimate businessmen may fail to register or keep proper records or refuse to permit access to or copying of records or entry or inspection unawares, and for reasons unconnected with any purpose to evade the prohibitions of the act, and under circumstances where such conduct is not likely to facilitate diversions. It is believed that felony status for such refusals and failures is appropriate only if they are done with knowledge that they are unlawful and with either what is in substance a purpose to evade the prohibitions of the Act or knowledge that they will further such evasions. Lesser failures and refusals may be treated as misdemeanors as discussed in the preceding subsection.

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[373] E.g., compare (accepting criminal liability for negligence at least under some circumstances) Comments to Model Penal Code, § 2.02, Tent. Draft No. 4, 123, 126–127 (1955); Comments to Model Penal Code, § 201.4 (now § 210.4), Tent. Draft No. 9, 49, 52–53 (1959); Howard, "Strict responsibility for negligence in the high court of Australia," 76 L.Q. Rev. 547 (1960); Wechsler and Michael, "A rationale of the law of homicide," 37 Colum. L. Rev. 701, 750–51 (1937), with (questioning criminal liability for negligence) Hall, General Principles of Criminal Law 135–39, 371–72 (2d ed. 1960); Williams, Criminal Law: The General Part § 43 (2d ed. 1961); Mueller, "Criminal liability of professionals based on negligence" (American report), a paper submitted to the Seventh International Congress of Comparative Law, at Uppsala, Sweden, passim (1966). Professor Williams does not reject criminal liability for negligence absolutely. He states:

> There is a half-way house between mens rea and strict responsibility which has not yet been properly utilised, and that is responsibility for negligence. In nearly all the public welfare offenses coming before the courts there has been at least negligence * * *. To put responsibility frankly upon personal negligence would not be a large practical charge, but would better accord with the general sense of right, while not weakening the effectiveness of the legislation. Williams, op. cit. supra, § 90 at 262.

[374] Comments to Model Penal Code, § 2.02, Tent. Draft No. 4, 123, 126–27 (1955).

[375] See the passage from Professor Williams' treatise quoted in note 373 *supra*.

[376] Williams, op. cit. supra, § 90 at 262; see Packer, "Mens rea and the supreme court," 1962 Sup. Ct. Rev. 107, 143–45 (1962).

Manufacturing, Possession, and Distribution Offenses. It is recommended that (1) unauthorized manufacture should constitute a felony if it is done knowingly and with the purpose to sell or otherwise dispose of a "depressant or stimulant drug"; (2) unauthorized possession should constitute a felony if the possession was knowing and, as discussed earlier, with a purpose to sell or otherwise dispose; and (3) both unauthorized sale or other disposition and the filling or refilling of a prescription in violation of the limitations imposed by the amendments should constitute a felony if done knowingly. Again, normal rules of justification would be applicable.

The requirement that the prohibited conduct must be knowing would lead to the result that an honest mistake of fact, even though not reasonable, would negative the mental element required for the offense. This is deemed appropriate. Felony treatment for the offenses under discussion would not seem warranted unless the defendant was aware of the facts giving rise to liability. Knowledge of illegality, however, would not be an element of the offense, so that an honest but unreasonable belief by the defendant that his conduct did not constitute an offense would not negate any element of the crime. But in accordance with the recommendation made with respect to misdemeanors involving "depressant or stimulant drugs" it is recommended that a belief that conduct does not constitute an offense should avoid liability to the same extent that such a belief is recognized as a defense under section 2.04(3) of the Model Penal Code.[377]

Reductions in Grade. It is further recommended that in a prosecution for any of the aggravated offenses proposed, for the proposed Federal deception offense or for any existing offense "with intent to defraud or mislead" the act should give authority to the trial judge after a verdict or finding of guilt of a felony, to reduce the grade of the offense to a misdemeanor if the defendant's conduct did not involve or was not directed to commercial distribution.[377a]

Commercial distributions and conduct directed to commercial distribution would seem to warrant severe treatment, and felony status is most appropriate where such conduct is involved. Noncommercial distributions present a somewhat closer case. A distinction could be made in grading by making commercial distribution, distribution for a commercial purpose or distribution for profit the basis of an aggravated offense. It is believed, however, that it is preferable to treat the absence of a commercial element as a discretionary ground for mitigation than to make the presence of such an element the basis of an aggravated offense. To treat the commercial element as part of the offense might present the prosecution with difficult problems of proof. In addition, some noncommercial distributions are probably as serious as commercial distributions. For example, the conduct of a person who administers LSD to a young child might properly be viewed as no less serious than a commercial distribution of the drug to an adult.

Penalties for Aggravated Offenses. It is recommended that the maximum penalty for the aggravated offenses proposed above be 3 years' imprisonment and a $10,000 fine.[377b] This is the maximum penalty under existing Federal law for offenses with intent to defraud or mislead, and is believed to be a reasonable maximum for the aggravated offenses proposed. It should be recognized that the proposal that unauthorized manufacture, possession, disposition, and prescription filling and refilling should constitute felonies if committed knowingly may have the effect of making a felony charge available to the Government in a significant number of cases where it is practically unavailable under existing law. The existing requirement that an offense be committed with intent to defraud or mislead may be so difficult to utilize in "depressant or stimulant drug" cases that the Government may be content to rely on the existing misdemeanor provisions. Since it will probably be able to prove that disposition, prescription filling and refilling, possession and manufacture were knowing in a significant number of cases, the Government will probably seek felony convictions more often if the proposals herein are adopted. It is believed, however, that society's interest in preventing unlawful distribution of "depressant or stimulant drugs" is significant enough to warrant felony treatment for offenses involving the circumstances of aggravation proposed herein. This is especially true where commercial distribution or conduct directed to commercial distribution is involved.

It is not recommended that any distinction for penalty purposes be drawn among the various offenses. They reach either distribution or conduct preparatory to distribution. It is believed that the mental elements proposed for the various preparatory offenses furnish a good assurance that a convicted defendant would have engaged in or furthered the ultimate offense of distribution had his activities progressed further or at least is the type of person likely to engage in illicit distribution.[378] Even if this should not be the case it is not believed that the maximum penalty proposed is so long that grading distinctions between actual distribution and any of the preparatory crimes are either necessary, appropriate, or feasible. When warranted, distinctions between actual distribution and a preparatory crime may be considered in sentencing individual defendants.

Misrepresentation and Deception

It is recommended that the proposed Federal offense involving misrepresentations and deceptions against manufacturers and wholesalers with a purpose to sell or otherwise dispose of the drug sought or obtained [379] should, like the aggravated offenses discussed above, constitute a felony punishable by a maximum term of 3 years' imprisonment and a $10,000 fine. The offense requires that the conduct be knowing, and by reaching only misrepresentations and deceptions with a purpose to sell or otherwise dispose is designed to reach large-scale diversions. As in the case of the Federal possession prohibition, proof that the deception was for distribution will ordinarily, though not always, involve a showing of deception directed to obtaining fairly large quantities of a controlled drug. It is believed that felony treatment for deceptive conduct which is calculated to result in large-scale diversions is appropriate.

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[377] See text preceding note 371, *supra*.

[377a] Compare Model Penal Code, § 6.12:

> If, when a person has been convicted of a felony, the Court, having regard to the nature and circumstances of the crime and to the history and character of the defendant, is of the view that it would be unduly harsh to sentence the offender in accordance with the Code, the Court may enter judgment of conviction for a lesser degree of felony or for a misdemeanor and impose sentence accordingly.

[377b] Even though they are permissible under the recommendations fines should not be indiscriminately imposed. Criteria for imposing fines are contained in Model Penal Code, § 7.02.

[378] It is believed that preparatory offenses may appropriately be directed to the actor's general disposition towards criminal activity as manifested by his conduct and proof of his state of mind on the particular occasion in question as well as to the likelihood that he would have engaged in the choate crime on that occasion. See Wechsler, Jones, and Korn, "The treatment of inchoate crimes in the model penal code of the American Law Institute: attempt, solicitation, and conspiracy: part one," 61 Colum. L. Rev. 571, 572 and passim (1961).

Sales to Minors

The 1965 amendments provide that a sale or other disposition of a controlled drug by a person 18 years of age or older [380] to a person under 21 is punishable by a maximum term of 2 years' imprisonment and a maximum fine of $5,000. Second offenders may incur 6 years' imprisonment and a fine of $15,000.[381]

These provisions were designed to deter those who might prey upon children and persons of high school and college age. Congress was impressed by reports of nonmedical use of dangerous drugs by both high school and college students.[382] In effect, Congress was attempting to afford special protection to children and persons of high school and college age.[383] Presumably, Congress viewed such persons as more likely to be untutored in matters relating to drugs than older persons and wanted them to remain so.

It should be recognized that legislation designed to protect those innocent in the ways of dangerous drugs that ties the offense solely to the age of the recipient will be more or less arbitrary in its application depending on the ages which it covers. The younger the recipient the more likely he is in fact to be untutored. Thus, where young children are involved such legislation would rarely be arbitrary. While an occasional young child may be as wise in the ways of the world as his elders, the vast majority of such children would be innocents. On the other hand, where the recipient is a teenager or a person just under 21 the likelihood that he is uninitiated is smaller. The number of teenagers and persons just under 21 who are as wise in the ways of the world as an adult is probably not insignificant, and the mere fact that a controlled drug is sold or given to a person in these age groups does not necessarily mean that the particular buyer or recipient is the innocent person Congress desired to protect. Conversely, the mere fact that a sale is made to an adult does not necessarily mean that the particular purchaser was not untutored. An appropriate cutoff age must to some degree be a matter of guesswork.

However, again it should be emphasized that the younger the buyer or recipient the more likely that he was the "innocent" person Congress desired to protect. Moreover, the more the seller distributes to young persons, the more likely it is that he will be selling to at least some persons who are "innocent." The likelihood that a seller may be selling to "innocents" may also be increased when he makes a sale to a minor in an area where minors habitually congregate such as in the vicinity of a school and college, and particularly where he customarily sells to minors in such an area. It is even more likely that the seller will be selling to an "innocent" where he initiates the transaction and most likely where the minor accepts the drug only after persuasion. These observations suggest that: (1) Sale or disposition to a person under the age of 14 (an admittedly arbitrary choice), (2) customarily selling or otherwise disposing to minors, (3) sale or disposition to a minor in an area in which minors habitually congregate, and (4) sales or disposition to a minor where the distributor initiates the transaction or persuades the minor to purchase or accept the drug, are appropriate considerations for increasing sentence either by way of being subjects of an aggravated offense or as aggravating factors to be considered by the trial judge in sentencing an offender after a conviction for the knowing and unjustifiable sale or disposition offense proposed earlier herein. Because they are more directly related to the evil Congress was presumably trying to prevent, it is believed that their use in either manner would be superior to the existing scheme under which the mere fact of sale to any minor is an aggravated offense.

It is recommended that these circumstances should be treated as possible aggravating factors in sentencing an offender after conviction of knowing sale rather than as the subjects of an aggravated offense. Aside from difficulties that might be encountered in proving some of these circumstances of aggravation, it is not believed that an aggravated offense is necessary. The purpose of an aggravated offense could be equally well served by considering these factors in sentencing for knowing sale. In most cases it should not be inordinately difficult for the Government to prove a knowing sale or other disposition. Consequently the seller could be convicted of a felony carrying a maximum penalty of 3 years' imprisonment. This maximum is longer than the 2-year maximum under the existing sale-to-minors provision, and to the extent that possible penalties do deter should be as effective a deterrent as a longer penalty.[384]

When the actor is charged with the misdemeanor sale and disposition offense proposed herein there would not seem to be sufficient basis for statutory aggravation when the sale or disposition was to a minor. The person who should have known that what he was selling or disposing of was a controlled drug but did not actually know is less culpable than the person who actually knew what it was that he was distributing. Whether the fact that the sale or disposition was to a minor or was to a minor under any of the circumstances discussed above should be considered by the judge sentencing for a misdemeanor is another matter.[385]

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[379] See text at notes 338–354, *supra.*

[380] An offender is not eligible for treatment as a juvenile offender under the Federal Juvenile Delinquency Act after he has attained his 18th birthday. (18 U.S.C., § 5031.)

[381] The act is somewhat ambiguous as to whether the 6-year maximum penalty applies only where there have been two or more convictions for sales or dispositions to minors or whether it also applies where one conviction is for such an offense and another conviction is for a violation of the act not involving a sale or disposition to a minor. As the author reads the provision the 6-year penalty would apply only in the first situation, and in the second situation the offender would be subject to the 3-year maximum applicable to other second offenders.

[382] See statements of: Representative Delaney of New York, 111 Congressional Record 4290, col. 3, 89th Cong., 1st sess. (daily ed., Mar. 9, 1965); Representative O'Neill of Mass., Id. at 4291, col. 1; Harris of Arkansas, Id., at 4295, col. 1.

[383] See statements of: Representative Rogers of Florida, 111 Congressional Record 4308, col. 2 (daily ed., Mar. 9, 1965) and 4575, col. 2 (daily ed., Mar. 10, 1965); Springer of Illinois, Id., at 4575, col. 2 and 3; Harris of Arkansas, Id., at 4575, col. 3.

[384] Cf., note, "Statutory structures for sentencing felons to prison," 60 Colum. L. Rev. 1134, 1149–50 n. 103 (1960).

[385] The problem of aggravation or enhancement of punishment for second and subsequent dispositions to minors is treated in the general discussion of "Punishment for subsequent offenses," *infra.*

Should the Commission determine that a grading distinction based solely on sale to a minor should be retained, it is recommended that a reasonable mistake on the part of the defendant as to the age of the purchaser should save him from liability for the aggravated offense. This might be accomplished either by treating such a mistake as a defense or by treating negligence as to the age of the purchaser or recipient as an element of the crime. To make the defendant's reasonable mistake irrelevant would be to impose strict liability as to the age of the purchaser where it is not justified. Where the cutoff age for aggravation is 21, 18, or some age between 21 and 18, the defendant who reasonably believes the purchaser was older than the cutoff age does not reveal himself as more of a threat to society than the person who sells to an adult.[386] Whether strict liability as to the age of the purchaser or recipient might be justified if the cutoff age were lower, such as 10 or 12, so that even if the defendant believed the child was older, his belief would indicate a greater departure from community standards than had he sold to an adult, is another question.[387]

Punishment for Subsequent Offenses [388]

The Food, Drug, and Cosmetic Act currently provides that a second or subsequent conviction for the sale or disposition of a "depressant or stimulant drug" to a minor is punishable by a maximum of 6 years' imprisonment and a $15,000 fine and that other second or subsequent convictions for offenses under the act are punishable by a maximum of 3 years' imprisonment and a $10,000 fine.

Aggravated Offenses. It is not recommended that aggravated penalties should be prescribed for second or subsequent aggravated offenses. It is submitted that the 3-year maximum penalty proposed for "depressant or stimulant drug" felonies should, especially if it or penalties close to it are actually imposed in appropriate cases, be as effective deterrent for even the person who has transgressed before as would a longer term.[389] The deterrent effect of criminal laws and sanctions may depend more on the likelihood of detection as seen by likely offenders and the likelihood that significant penalty will in fact be imposed [390] than on the mere existence of a prohibition or of a long statutory maximum penalty. Moreover, to the extent that the mere existence of a statutory penalty is a deterrent, there is no reason to believe that a 3-year maximum would be a less effective deterrent than would a longer maximum term.[391] It is not believed that subsequent offenses involving sales to minors should be treated any differently than other subsequent offenses. The 3-year maximum can be as effective deterrent to these offenses as to other subsequent offenses. Of course, enhancement of punishment for subsequent offenders might be deemed appropriate, without regard to its deterrent effect, in order to isolate habitual offenders. It is submitted, however, that in the absence both of a general Federal habitual offender statute and of any experience under the penalty provision of the 1965 amendments it would be inappropriate to single out "depressant and stimulant drug" offenders for such treatment.

Misdemeanors. It is also believed that under the proposals herein statutory aggravation of penalties for second and subsequent offenders who have committed misdemeanors relating to "depressant or stimulant drugs" is unwarranted. When a person who has once been convicted of a misdemeanor under the act violates the act a second time it should not be particularly difficult to prove that the second offense was knowing, and thus subject him to the penalties for a felony in the case of an offense such as sale where knowledge is the basis of felony treatment under the proposals herein. Even in the case of such aggravated offenses as failure to register or to keep proper records where proof of a state of mind more culpable than knowledge is proposed, the earlier transaction may help to prove the required culpability. When it does not, regardless of the number of prior offenses committed, it is not believed that the conduct prohibited by these offenses should lead to conviction of a felony unless the culpability recommended is proven.

Cumulation of Penalties and Multiple Convictions

A defendant may at one trial be convicted of two or more offenses under the act involving "depressant or stimulant drugs" or he may be convicted of one or more such offenses at one trial and at a subsequent trial convicted of one or more other "depressant or stimulant drug" offenses committed prior to the first conviction. Under Federal law the trial judge may in his discretion cumulate penalties for these offenses.[392] Cumulation of penalties usually takes the form of consecutive prison sentences but may also involve multiplication of fines where fines are authorized.[393] Despite the general power to cumulate penalties under Federal law, there has been litigation as to whether cumulation is permissible where the offenses are in some way related. Related offenses may involve multiple violations of the same statutory prohibition committed at one time or closely connected in time,[394] violations of different statutory prohibitions committed at one time or closely connected in time,[395] or violations of statutory prohibitions which forbid different steps in a course of conduct leading up to a prohibited end or which prohibit a step and the end.[396] The problems presented are complex.

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[386] Cf., the discussion with respect to sex crimes in which the age of the partner is a relevant circumstance, in Model Penal Code, Tent. Draft No. 4, at 253 (1955).

[387] See Ibid.

[388] As used herein a second or subsequent offense is an offense committed after a prior conviction for an offense under the act (or in the case of a sale or disposition to a minor, after a prior conviction for a sale or disposition to a minor) has become final. See Food, Drug, and Cosmetic Act, § 303(a), 21 U.S.C., § 333(a).

[389] Cf., note, "Statutory structures for sentencing felons to prison," 60 Colum. L. Rev. 1134, 1149–50 n. 103 (1960).

[390] See Gardiner, "The purposes of criminal punishment," 21 Mod. L. Rev. 117, 123, 125 (1958). Cf., Hall, Theft, Law and Society 327 (2d ed. 1952). Certainty of punishment has often been stressed as important to deterrence. E.g., Bentham, "Principles of penal law," pt. II, Book 1, ch. 6, in 1 Bentham's Works 401–02 (Bowring ed. 1843).

While it might seem that mandatory minimum penalties might have a greater deterrent effect because of their theoretical certainty of application upon detection and conviction, Professor Aronowitz's report to the Commission points out that the application of mandatory minimum penalties under the narcotics laws has been anything but certain and that there is no substantiated evidence that such penalties have had a significant deterrent effect under those laws. Aronowitz Report at 24–27. In any event, mandatory penalties are undesirable because of the limits they impose on individualization of punishment. See text at notes 405–406, *infra*.

[391] Cf., note, 60 Colum. L. Rev., *supra* at 1149–50 n. 103.

[392] *Papalardo* v. *United States*, 260 F. 2d 326 (6 Cir. 1958); cf., *United States* v. *Daugherty*, 269 U.S. 360 (1926).

[393] The entry of multiple judgments of conviction and the imposition of concurrent sentences might also be regarded as cumulation of punishment, but they are not so regarded under Federal law. See note, "Twice in jeopardy," 75 Yale L.J. 262, n. 161 at 299–300 (1965).

[394] E.g., *Ladner* v. *United States*, 358 U.S. 169 (1958) (one discharge of shot gun injuring two Federal officials under statute prohibiting assaulting a Federal officer); *Bell* v. *United States*, 349 U.S. 81 (1955) (one transportation of two women under provision of Mann Act prohibiting transportation of "any woman"); *Blockburger* v. *United States*, 284 U.S. 299 (1932) (multiple sales of narcotics within a short time to the same purchaser); *U.S.* v. *Adams*, 281 U.S. 202 (1930) (multiple bookkeeping entries apparently made successively under provision of Federal Reserve Act prohibiting making of "any false entry" with intent to defraud); *United States* v. *Daugherty*, 269 U.S. 360 (1926) (multiple sales of narcotics within a relatively short period to different purchasers); *Ebeling* v. *Morgan*, 237 U.S. 625 (1915) (multiple cuttings of mail bags in rapid succession under statute prohibiting cutting or tearing of "any mail bag" with intent to rob or steal the mail).

In recent cases the Supreme Court has appropriately treated these problems as presenting questions of statutory interpretation,[397] the Court's conclusion depending upon whether or not it believes cumulation for the offenses in question would further a purpose of Congress in enacting the legislation in question. Often the Court must choose between two purposes, each of which points to a different result.[398] In recent cases the Court has usually, but not always, resolved doubts by concluding that the imposition of consecutive sentences was not authorized by Congress [399] and has left it to Congress to expressly state when it wishes to authorize cumulation of penalties.[400] In this light it would be advisable to explicitly resolve cumulation questions under the act involving "depressant or stimulant drug" offenses.

It should be recognized that the problems presented by cumulation of penalties are not solely problems involving related offenses. Problems may arise with respect to cumulation for unrelated offenses for which a defendant is sentenced at one trial, or for which he is sentenced at separate trials when one or more of the offenses for which he is sentenced at the second trial was committed prior to the first conviction. An unlimited power to cumulate penalties may permit sentences so long that they preclude the possibility of rehabilitation, so long that they make it unlikely that when the defendant returns to society he will be able to do so as a reasonably well-functioning individual, or so long that they are meaningless.[401] In addition, when consecutive sentences imposed upon multiple offenders for offenses which are not commonly viewed as of the most serious kind approach in length sentences commonly imposed for the most serious crimes, the grading scheme may be distorted and the gravity of the sanction for the greater crime may be depreciated.[402]

A statutory decision as to whether or not to permit cumulation of penalties is, of course, a decision as to maximum penalties and like any other decision as to penalties may be made for many reasons. In the author's opinion, cumulation may appropriately be barred if it is believed that the multiple violations that may reasonably be anticipated are not likely to involve criminality more extensive than that likely to be involved in single violations or that the maximum penalty that may be imposed for a single violation is adequate (e.g., is long enough) even for those multiple offense situations involving extensive criminality which may reasonably be foreseen.

Some multiple offenses involving "depressant or stimulant drugs" may involve criminality more extensive than does a single offense, and some may not. Multiple sales of small quantities of a controlled drug probably do not suggest criminality as extensive as a single sale of a very large quantity. While it can be argued that the repetition, especially if to different persons, suggests criminality at least as extensive, it is submitted that the single distribution of very large quantities is more significant, because it may suggest a large-scale operation. On the other hand, multiple distributions of very large quantities may indicate criminality more extensive than does one such distribution. But even in this situation it may be that the additional distribution or distributions are not particularly significant insofar as it or they merely confirm what the first distribution suggested.

Even recognizing the possibility that some multiple offenses relating to "depressant or stimulant drugs" may suggest criminality more extensive than does a single offense, it is believed that the penalties proposed herein for single felonies and misdemeanors, respectively, are long enough to serve the ends of sentencing even in the great majority of situations that may arise. For example, it is believed that the 3-year maximum penalty for knowing sale is long enough to serve the ends of sentencing even for multiple sales involving large quantities of a controlled drug. Consequently, it is recommended that the act should generally prohibit cumulation of penalties for "depressant or stimulant drug" offenses, whether or not related, both in the case of multiple convictions after one trial and in the case of multiple convictions after separate trials.

It may be objected that even if the penalties proposed for single offenses are otherwise adequate for multiple offenses, to bar cumulation would be to say to prospective violators that they can commit additional offenses with impunity and, thus, forgo a possible deterrent to such offenses. However, in addition to the likelihood that trial judges will often impose heavier sentences on multiple offenders than single offenders, it is questionable to what extent the possibility of enhancement of penalties for multiple offenses actually has a deterrent effect on the commission of additional offenses when multiple offenses have been committed before the defendant has been charged with the commission of any offense.

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[395] E.g., *Gore* v. *United States*, 357 U.S. 386 (1958) (one sale of narcotics in violation of three provisions, all prohibiting sale of narcotics but under different circumstances); *Prince* v. *United States*, 352 U.S. 322 (1957) (bank robbery and entry into bank immediately preceding it under National Bank Robbery Act provisions prohibiting bank robbery and entry with intent to commit a felony); *Blockburger* v. *United States*, 284 U.S. 299 (1932) (one sale of narcotics in violation of two provisions, each prohibiting sale of narcotics but under different circumstances); *Albrecht* v. *United States*, 273 U.S. 1 (1927) (possession and sale of same alcohol under National Prohibition Act); *Morgan* v. *Devine*, 237 U.S. 632 (1915) (post office larceny and entry into post office immediately preceding it under provisions prohibiting larceny of post office and "forcible" breaking into post office with intent to commit larceny). See also *Williams* v. *Oklahoma*, 358 U.S. 576 (1959) (state prosecutions for kidnapping and murder following the kidnapping).

[396] The offenses created by the 1965 Drug Abuse Control Amendments and offenses created under other regulatory schemes such as the narcotics laws and the former National Prohibition Act are prime examples. The "steps" are often closely related in time, but they need not be. In the case of conspiracy and the substantive offense which is its object—another example—(see *Callanan* v. *United States*, 364 U.S. 587 (1961); *Pinkerton* v. *United States*, 328 U.S. 640 (1946)), the formation of the conspiracy may precede the occurrence of the substantive offense by a considerable time. There is a good deal of overlap between this class of related offenses and violations of different prohibitions closely connected in time. See *Prince* v. *United States; Albrecht* v. *United States, and Morgan* v. *Devine*, all cited in the preceding note.

[397] E.g., *Callanan* v. *United States*, supra; *Heflin* v. *United States*, 358 U.S. 415 (1959); *Ladner* v. *United States*, 358 U.S. 169 (1958); *Gore* v. *United States*, 357 U.S. 386 (1958); *Prince* v. *United States*, 352 U.S. 322 (1957); *Bell* v. *United States*, 349 U.S. 81 (1955); *United States* v. *Universal C.I.T. Credit Corp.*, 344 U.S. 218 (1952). See note, "Twice in jeopardy," 75 Yale L.J. 262, 302–04, 311–13 (1965).

[398] E.g., *Gore* v. *United States*, supra; *Bell* v. *United States*, supra.

[399] E.g., *Heflin* v. *United States*, 348 U.S. 415 (1959); *Ladner* v. *United States*, 358 U.S. 169 (1958); *Prince* v. *United States*, 352 U.S. 322 (1957); *Bell* v. *United States*, 349 U.S. 81; *United States* v. *Universal C.I.T. Credit Corp.*, 344 U.S. 218 (1952).

In *Gore* v. *United States*, 357 U.S. 386 (1958) (single sales of narcotics resulting in violations of three provisions all prohibiting sale of narcotics, but under different circumstances) and *Callanan* v. *United States*, 364 U.S. 587 (1961) (conspiracy to obstruct commerce by extortion and obstructing commerce by the same extortion) the Court interpreted the statutes to authorize cumulation of penalties. In early cases, it upheld cumulation of penalties more readily.

[400] See the cases cited in the first paragraph of the preceding note.

[401] The comments to the Model Penal Code (comments to § 7.03, Tent. Draft No. 2, 44 (1954)) refer to "occasional anomolies such as a sentence of 100 years." Given normal life spans, such sentences are so long as to be meaningless in that they are beyond the comprehension of the ordinary citizen and may, depending upon parole availability and eligibility and other factors, actually be sentences of life imprisonment. While long prison terms and even a sentence of life imprisonment may be appropriate in some cases of multiple criminality, sentences should be meaningful. The imposition under proper legislative authorization of life imprisonment for certain types of multiple offenders would be more meaningful.

The Model Penal Code puts some limits on enhancement of punishment for multiple offenders. See §§ 7.03, 7.06.

[402] In *O'Neill* v. *Vermont*, 144 U.S. 323 (1892) the defendant had been sentenced to over 54 years imprisonment for 307 unlawful sales of liquor. The Supreme Court dismissed the writ of error, never reaching the issue of cruel and unusual punishment. Mr. Justice Field, dissenting, believed the sentence a cruel and unusual punishment and pointed out:

> Had he been found guilty of burglary or highway robbery, he would have received less punishment than for the offenses of which he was convicted. It was six times as great as any court in Vermont could have imposed for manslaughter, forgery or perjury. 144 U.S. at 337, 339.

It is not believed that the fact that Mr. Justice Field was comparing penalties for multiple offenses with penalties for single offenses detracts from the comparison.

In *Ebeling* v. *Morgan*, 237 U.S. 625 (1915) the defendant was sentenced to 15 years imprisonment for cutting or tearing six mailbags in rapid succession in violation of a statute which prohibited the cutting or tearing of any mailbag with intent to steal the contents of the bag. Compare this with the maximum penalty of 20 years' imprisonment or less by which second-degree murder is punishable in some States. Md. Ann. Code, art. 27, § 414 (1957) (5 to 18 years); Pa. Stat. Ann., title 18, § 4701 (1963) (20 years); Tenn. Code Ann., § 39–2408 (10 to 20 years) (1955). Second-degree murder is punishable by a maximum penalty of life imprisonment under Federal law. (18 U.S.C. § 1111(b).)

However, it is recommended that cumulation limited to a maximum term of 5 or 6 years and a maximum fine of $20,000 when one of the charges involved is a "depressant or stimulant drug" felony and a maximum term of 2 years and a maximum fine of $2,000 when no felony is involved should be permitted, in the discretion of the trial judge, when at least one of the offenses of which the defendant is convicted is committed after he is charged with another "depressant or stimulant drug" offense and before sentence for that prior offense is imposed. This recommendation deals with the situation where a defendant charged with one offense commits another before sentence for the first, because he believes he has nothing to lose by doing so. It is believed both that such a defendant has demonstrated a greater antisocial attitude than the defendant who has committed multiple offenses before he is charged with an offense, and that there is some likelihood that the imposition of longer sentences in such cases might deter some of these second offenses. The limitation on cumulation which is proposed even in this situation is to prevent the imposition of unduly long sentences. For this reason it is recommended that even if the Commission should reject a general bar on cumulation, it should recommend a general limitation on cumulation of penalties for offenses relating to controlled drugs to not more than 5 or 6 years and a $20,000 fine when one of the charges involved is a felony and not more than 2 years and a $2,000 fine when no felony is involved. The 6-year limitation would permit consecutive sentences of no more than twice the length of the maximum sentence for a single felony or misdemeanor, respectively. A 5-year limitation where a felony is involved may be preferable, however, because it would avoid introducing another statutory maximum penalty into Federal law.[403] The 5-year maximum is a common penalty for Federal crimes.

The recommendation that the act should permit the entry of only one judgment of conviction where the defendant is charged solely with multiple offenses relating only to a single distribution is made, because, with the exception of the proposed Federal deception offense, all of the offenses proposed herein as well as all of the existing "depressant or stimulant drug" offenses under the act are directed solely at unlawful distribution. They either prohibit such distribution itself as the sale or disposition and prescription offenses do, or reach conduct which is either preparatory or auxiliary to it.

Preparatory conduct, like possession and manufacture, is properly punishable solely because it creates a risk that unlawful distribution will occur.[403a] As the comments to the model penal code state with respect to conspiracy—another preparatory crime—"the measure of its danger is the risk of such a culmination." [404] When the culmination has occurred there is no reason to punish the actor both for creating the risk of succeeding and for succeeding. Nor is there reason to enhance the punishment of the actor who has not succeeded, when he takes more than one preliminary step—as when he manufactures and then possesses. This is particularly true where as under both the existing act and the proposals, the maximum punishment for one preliminary step is the same as the maximum punishment for the consummation. The creation of a risk of harm should incur no greater punishment than the harm itself.

These considerations also suggest that only a single judgment of conviction should be entered where all the offenses relate only to a single distribution. A single judgment of conviction for preparatory offenses finds some support in section 1.07(b) of the model penal code. "When the same conduct of a defendant may establish the commission of more than one offense" that section permits conviction of only a single offense if "one offense consists only of a conspiracy or other form of preparation to commit the other."

Failure to register; failure to prepare, obtain, or keep complete records; refusal to permit access to or copying of records; and refusal to permit entry or inspection should be treated similarly. While in a sense preparatory offenses, these offenses are more correctly considered as offenses auxiliary to unlawful distribution. They may occur in connection with an unlawful distribution or they may not; when they do occur in connection with such a distribution they may take place before the distribution or after. Thus, records may be falsified, registration omitted, or entry or inspection refused either before or after an unlawful distribution. Sometimes such conduct will wittingly or unwittingly facilitate unlawful distribution or manufacture by making it more difficult to detect. But in any case, these offenses exist solely to make unlawful distributions more difficult and to deter such distributions. When an unlawful distribution does take place and is discovered there is no more reason to permit additional punishment or another conviction for creating the risk that it will take place or for creating the risk that it will go undetected than there is when unlawful possession or manufacture leads to unlawful distribution. Similarly, when the actor commits two or more of these offenses but never reaches the stage of distribution, he should neither be punished nor convicted for more than one. Again, the creation of a risk of harm should not be treated more severely than the occurrence of that harm.

It is not recommended that the bar on multiple convictions for offenses relating solely to a single distribution apply to the proposed Federal deception offense. This offense is at least in part intended to vindicate an interest somewhat different from that which the "depressant or stimulant drug" offenses under existing Federal law and variants of those offenses proposed herein are intended to vindicate. That interest is in protecting the integrity of the system of distribution which Congress has created or recognized from diversions attempted or accomplished by a particular type of conduct.

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[403] It should be noted, however, the maximum period of confinement for an offender sentenced under the Federal Youth Corrections Act is normally 6 years. (18 U.S.C. § 5017(c).)

[403a] Of course preparatory offenses may also be directed at use or at acquisition. The undesirability of punishment for use and acquisition has already been discussed.

[404] Comments to Model Penal Code § 5.03, Tent. Draft No. 10, 99 (1960). See also comments to § 1.08 (now § 1.07), Tent. Draft No. 5, 32-33.

However, while it is believed that the evil it is directed against is significant enough to support the offense proposed and to support the entry of a judgment of conviction for that offense even though the offense relates to the same distribution as do other offenses, it is not believed that that evil is significant enough to warrant cumulation of penalties for the deception offense and for another offense relating to the same distribution. Consequently, even if the Commission should not recommend a general bar on cumulation of penalties, it should recommend a bar on cumulation in this situation.

Mandatory Minimum Penalties and Prohibitions on Probation and Parole

The foregoing recommendations for penalties for "depressant or stimulant drug" violations speak of maximum penalties only. It is not recommended that mandatory minimum penalties be prescribed for these violations or that the normal discretion of the trial judge to impose probation, a suspended sentence, or young adult treatment or of the parole board to parole offenders be limited or abolished with respect to violators of these provisions. These matters have been thoroughly considered with respect to narcotic offenses and narcotics violators by Professor Aronowitz in his report to the Commission,[405] and it is believed his conclusions apply also to "depressant and stimulant drugs."

It should be emphasized that in addition to their other drawbacks, mandatory minimum terms of imprisonment and statutes which make suspended sentences, probation, young adult treatment, and parole unavailable, limit the usual discretion available to sentencing judges and parole boards to individualize punishment to fit the offender as well as the offense. If ever appropriate, such restrictions should at least not be lightly imposed and certainly not when regulation of the traffic in "depressant or stimulant drugs" is in its infancy, and there is no sufficient body of experience to indicate whether they are necessary. In this connection, it should be noted that former Commissioner Larrick of the FDA, the agency charged with enforcement of the Federal law, testified in opposition to mandatory minimum penalties during the hearings before the House Committee on Interstate and Foreign Commerce which preceded the enactment of H.R. 2.[406]

To have mandatory minimum penalties but to make probation and suspended sentences available would not significantly improve the situation that obtains where mandatory minimum penalties exist, and probation and suspended sentences are unavailable. Unless the mandatory minimum penalty was so low as appropriately to be reckoned in terms of a few days, a judge might decide to place a defendant who he believes should be given a short jail sentence on probation or to suspend sentence, rather than to sentence him to a significant mandatory term.

SMUGGLING

In recent years there has been some demand for Federal legislation specifically prohibiting smuggling of dangerous drugs and providing for penalties in some respects greater than the penalties which attach to smuggling of other articles.[407] A bill introduced in the current session of Congress would prohibit knowing importation of "depressant or stimulant drugs" for the purpose of manufacture or disposition in "violation of the laws of the United States."[408] It would make first violations punishable by a maximum of 5 years' imprisonment and a $10,000 fine. Second and subsequent offenses would be punishable by a maximum of 10 years' imprisonment and a $20,000 fine.

The general Federal smuggling provision[409] provides for a maximum of 5 years' imprisonment and a $10,000 fine, and a number of other customs violations provide for a maximum of 2 years' imprisonment and a $5,000 fine.[410] In this light it is not believed that any significant purpose would be served by proposals such as those referred to above. Existing penalties are certainly adequate for the disposition of offenders. The real problem is detection, and this is, of course, difficult. It is not believed that the enactment of special legislation dealing with smuggling of controlled drugs or providing for an increase in statutory penalties would have a deterrent effect any greater than the deterrent effect of existing prohibitions and existing penalties. If the law is to deter in this situation, it must be through increasing the likelihood of detection. A similar recommendation was made by the President's Advisory Commission on Narcotic and Drug Abuse:[411]

> The Commission views additional legislation as being of relatively little value, since the general smuggling law already provides for a maximum prison term of 5 years. The answer is not to enact stronger laws, but to strengthen enforcement of the existing laws. If the Bureau of Customs can institute more frequent and more thorough searches at the points of entry along our borders, as the Commission has suggested, drug smuggling should decline markedly.

COMMENTS TO STATE RECOMMENDATIONS

DEFINITION OF CONTROLLED DRUGS

It is recommended that State law should define controlled drugs as the Federal law defines them and that a Federal determination that a drug is a "depressant or stimulant drug" should automatically make it a "depressant or stimulant drug" under State law. This approach is followed in the Model State Drug Abuse Control Act.[412]

Once a drug is controlled under the Federal amendments, State law cannot exempt even intrastate commerce in that drug from Federal regulation, because the Federal amendments apply to controlled drugs regardless of their interstate or intrastate character. If such a drug is automatically subjected to State law upon its designation as a "depressant or stimulant drug" under Federal law, State authorities will be able to immediately join Federal authorities in regulating it without being required to wait for a State designation.

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[405] Aronowitz Report at 24–27.

[406] Testimony of Commissioner George P. Larrick, Feb. 10, 1965, House Hearings, at 359.

[407] See, e.g., statement of Senator Dodd of Connecticut on the introduction of S. 3183, 89th Cong., 2d sess. (Apr. 5, 1966).

[408] S. 3183, 39th Cong., 2d sess. (introduced on Apr. 5, 1966 by Senator Dodd of Connecticut).

[409] 18 U.S.C., § 545. Under this provision possession of smuggled goods, "unless explained to the satisfaction of the jury, shall be deemed sufficient evidence to authorize conviction * * *."

[410] See 18 U.S.C., §§ 541–42.

[411] President's Advisory Commission on Narcotic and Drug Abuse, Final Report 48 (1963).

[412] Model State Drug Abuse Control Act, § 1(d).

While State law might adopt a more inclusive definition of a "depressant or stimulant drug" than the Federal definition, there is no reason to believe that the Federal definition is not sufficiently broad. Of course, a State agency could be given authority to apply a definition or criteria identical with that in the Federal act. Under such a scheme the State agency could normally be expected to designate drugs which are designated under the Federal act, and, in addition, it might designate drugs which had not been designated under the Federal act. It would seem, however, that it would be more difficult for a State agency to apply the "potential for abuse" standard of the Federal act than it is for the FDA. Application of that standard involves difficult technical and scientific questions, and it would appear that by virtue of its facilities, manpower, and background, the FDA is better equipped to reach judgments under it than are most State agencies. Moreover, the studies, procedures and hearings incidental to independent State judgments under such a standard would require duplication of efforts by governmental agencies and private persons alike.

It is recognized that some States may desire to confer authority upon a State agency to meet local problems. It is recommended that in those states a further provision conferring authority on an appropriate agency to designate a drug as a "depressant or stimulant drug" based upon its record of actual abuse within the State should be enacted. While such a standard would not totally eliminate duplication of efforts, it would give a State agency authority to reach peculiarly local problems. In addition, the standard of actual abuse would probably not involve scientific and technical questions quite as difficult as those involved in the application of the "potential for abuse" standard. The pending legislation in New Jersey which defines as a "depressant or stimulant drug" a drug which has been designated as a "depressant or stimulant drug" by the Secretary of Health, Education, and Welfare under the Federal act,[413] also gives the State commissioner of health authority to define as a "depressant or stimulant drug": [414]

> any drug which contains any quantity of a substance which the Commissioner, after investigation, has found, and by regulation designated as posing a threat to the public health by virtue of its record of actual abuse within this State because of its depressant or stimulant effect on the central nervous system or its hallucinogenic effect.

It should be noted, however, that there is a possibility that by the time a local drug problem becomes so acute that there is a record of actual abuse within a State or such a record of abuse that the drug poses a threat to the public health, the drug may already have been designated by Federal officials under the "potential for abuse" standard.

PRECURSORS

If the recommendations for Federal control of precursors made herein are adopted, a model State act should provide that a precursor is automatically to be controlled under it upon a determination by the Secretary of Health, Education, and Welfare that the precursor is to be controlled under the Federal act. The reasons which support automatic inclusion under a model State act of drugs designated as "depressant or stimulant drugs" under the Federal act also support automatic inclusion of precursors when they are controlled under the Federal act.

As in the case of "depressant or stimulant drugs" some States may desire to confer authority upon State agencies to meet local problems. This may be accomplished by the enactment of a further provision conferring authority upon an appropriate State agency to subject a precursor to the controls of the act when it determines that (1) the "depressant or stimulant drug" of which it is a precursor has no significant nonexperimental medical use in the United States and (2) the precursor is being used in the manufacture of the "depressant or stimulant drug" within the State otherwise than as authorized by the act. It should be noted, however, that—as in the case of State authority to designate a drug as a "depressant or stimulant drug" based on its record of actual abuse within the State—by the time State action to control a precursor under this standard is possible, the precursor may already have been subject to control under the proposal made herein for Federal control of precursors.

It is believed that even if the Federal act is not changed to give the Secretary of Health, Education, and Welfare authority to control certain precursors, the desirability of controlling percursors is great enough that a model State act should give appropriate State agencies authority to control them on the same basis as it has been recommended that they should be subject to Federal control.

REGISTRATIONS AND LISTINGS

It is recommended that a model State act contain registration and listing provisions as outlined.[414a] The provisions proposed are based on an approach embodied in pending legislation in New Jersey [415] but are generally more extensive in scope than the provisions of that legislation. The purpose of such provisions is to give each State enforcement agency information as to the persons in a State who, at each level of distribution, legitimately handle or who legitimately possess controlled drugs or who are most likely to handle or possess them. It is anticipated that the registration and listing requirements proposed will give the State enforcement agency some idea of the extent of legitimate traffic in controlled drugs and of possible sources of diversion from legitimate channels within a State. Furthermore, it is believed that the requirement that information as to particular registrants and as to licensees and registrants under other State laws must be made available for public inspection will help to enable a person endeavoring to comply with the act to discover any person with whom he deals who may be attempting to misrepresent his authority to deal in controlled drugs.

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[413] N.J. Assembly No. 548, §§ 1(a) (1), (2), (3) (introduced March 14, 1966).
[414] Id., § 1(a)(4).
[414a] See the recommendation, supra.
[415] Id., § 2(a)-(c).

The scheme of registrations and listings proposed would reach the most common levels of authorized distribution and possession. It would apply to all practitioners, pharmacists, pharmacies, hospitals, clinics, and public health agencies regardless of whether individual members of these groups in fact handle or possess controlled drugs. Most members of these groups do possess or handle controlled drugs and, consequently, are possible sources of diversion. Since practitioners are everywhere licensed, they would not have to register under the act. However, the agencies which license them would be required to furnish lists of their licensees to the enforcement agency at specified intervals. Practitioners would be exempt from the recordkeeping provisions of the act as they are under the Federal amendments.

The recently prepared Model State Drug Abuse Control Act contains no State registration provision. However, the author believes that State registration of manufacturers and wholesalers is desirable. While the States will primarily deal with retail traffic, they will also deal with traffic at higher levels of distribution to some extent. Despite the fact that there is every likelihood of close cooperation between the FDA and State enforcement authorities, it is doubtful if the FDA can supply State enforcement agencies with information as to Federal registrations of in-State establishments as quickly or effectively as the States themselves can secure that information. There are bound to be some gaps and lags if the States obtain the information from the FDA. While this may also be true to some extent with respect to information involving others who are authorized to deal in or possess controlled drugs, such as pharmacists, practitioners and hospitals, for whom listing and referral by State agencies are proposed, it is believed that lags in information can be tolerated less at the manufacturer and wholesaler level. These are the levels of distribution where there is greater opportunity for large diversions.

Because the State registration requirement for manufacturers and wholesalers will be satisfied by forwarding a copy of the registrant's Federal registration to the State enforcement agency,[416] it is believed that the burden of State registration on manufacturers and wholesalers will be minimal. The forwarding requirement will also show the State enforcement agency that the registrant is registered under Federal law.

The recommendations here made will usually impose no burden on practitioners, pharmacists and pharmacies, and hospitals. These groups are normally required to obtain a license from or to register with a State agency in order to practice or operate. If they are registered with or licensed by a State agency they would not be required to register under the model act. Rather, the agencies with which they are registered or by which they are licensed would forward lists of their licensees or registrants to the enforcement agency at specified intervals. Only if registration or a license to operate or practice is not required under State law will registration under the act be necessary. Even then providing the information required should not be a burdensome task. In some States it is possible that the State board of pharmacy will be the enforcement agency. In such States the board will compile lists of pharmacists and pharmacies for its own use in enforcing the dangerous drug law.

Hospitals, clinics, or public health agencies which are not subject to licensing or registration requirements to operate but which are nonetheless under the supervision of a State agency would not be required to register under the act. However, the supervising agency would be required to furnish to the enforcement agency periodic lists of the institutions under its supervision. Laboratories, research, and educational institutions and others that use controlled drugs in research, chemical analysis, or teaching would be required to register under the Act, but, again, it should be no burden to furnish the information requested.

Most drug warehousers are manufacturers or wholesalers within the meaning of the Federal act, and consequently are registered under it.[417] These warehousers would merely be required to supply copies of their Federal registrations to the State enforcement agency.

It should be emphasized that the recommendations herein call for registration, not licensing. Establishment of a licensing system such as exists in New York under which licensees would be required to submit proof of good moral character and of facilities sufficient to engage in business was considered in the course of this study. However, the author believes that before such a system is recommended for general adoption it should first be determined whether a system of registration based on the 1965 Federal amendments is adequate.

The registration requirements would not apply to out-of-State manufacturers and wholesalers who do not have an establishment or place of business within the State. It is believed that for reasons of uniformity the classes of persons exempt from the manufacturing, disposition, and possession prohibitions of the Federal act should also be exempt from the similar prohibitions of a model State act. It should be emphasized that the exemptions from the disposition and possession prohibitions should apply to out-of-State manufacturers and wholesalers who are registered under the Federal act but who do not have an establishment or place of business within the State and who, therefore, would not be required to register under the State act, and to their employees acting in the course of their employment. In addition, out-of-State practitioners should be permitted to possess controlled drugs within the State and in emergencies to dispense or administer such drugs for the immediate needs of patients. Physicians commonly carry their medical bags with them on vacations to be prepared for an emergency. They should be able to dispense or administer controlled drugs if an emergency does arise even though they are not licensed in the State.

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[416] Cf., Mass. Gen. Laws, ch. 94, § 187F (Supp. 1965) (forwarding copy of Federal registration satisfies requirement for licensing of out-of-State manufacturers and wholesalers).

[417] The author has been informed that most drug warehouses are owned by drug manufacturers or wholesalers.

RECORDKEEPING AND INSPECTION PROVISIONS

Recordkeeping and inspection provisions are at the heart of the regulatory scheme. A State act without such provisions would be meaningless. If the States are to have a significant role in dealing with illicit distribution of dangerous drugs, as the author has assumed, State law should contain such provisions. To the extent that the States provide manpower to enforce them, they will be able to make inspections that the FDA cannot make and contribute to the effectiveness of regulation.

A model State act should contain recordkeeping and inspection provisions like those contained in the 1965 Federal amendments. It should also contain provisions for better availability of records, reports of theft or loss, and for initial inventories of newly designated drugs like those recommended for Federal law.[418]

If the Federal act is amended—as proposed—to provide for better availability of records, a model State act should in addition provide that records and initial inventories prepared and kept in compliance with the recordkeeping requirements of the Federal act and regulations under it will satisfy State initial inventory and recordkeeping requirements if they are made available, upon request, to the State enforcement agency. If the Federal act is not so amended, however, a model act containing a provision for better availability of records should not treat compliance with Federal law as sufficient. If the recommended provision for better availability of records is neither added to Federal law nor contained in a State act, the State act should treat compliance with Federal law as sufficient compliance with its recordkeeping and inventory requirements.

It is believed that the recommendation for better availability of records is important enough to warrant its inclusion in a model State act even if it should not be included in the Federal act. On the other hand, it is believed that if this requirement is complied with or if neither the Federal nor State act adopt it, there would seem to be no need to subject legitimate business and professionals to two different sets of recordkeeping requirements.

In the course of this study consideration was given to the inclusion in model legislation of detailed recordkeeping requirements for hospitals such as appeared in the New York law before it was amended in July 1966.[418a] On balance, it is believed that if such requirements are to be instituted, they should be instituted by legislation in individual States in which diversions from hospitals are a serious problem.

BASIS OF LIABILITY, GRADING AND PENALTIES

It is recommended that the basis of liability for offenses under a model State act should parallel that proposed for Federal law. If strict liability is desired it should lead to civil penalties only. Negligence would be an appropriate basis of liability for unaggravated offenses, and it is believed that the proposals for aggravated offenses under Federal law are appropriate for State law also.

A question may be raised as to whether within this scheme a model State act should contain suggested penalties for violations of its provisions. The Uniform Narcotic Drug Act[419] and the Model State Drug Abuse Control Act[420] contain penalty sections but do not suggest specific penalties. Presumably this approach was taken out of respect for what is believed to be a peculiar sensitivity on the part of the States to what might be regarded as interferences with their rights to prescribe penalties for violations of their own laws. The Model State Barbiturate Act contains suggested penalties.[421] The Model Penal Code prescribes penalties for violations of the offenses it creates, and, it goes without saying that the Model Sentencing Act proposed by the Advisory Council of Judges of the National Council on Crime and Delinquency[422] deals with penalties. It is believed that suggested penalties should be included in a model State act dealing with dangerous drugs and in the framework for such an act, because the regulatory scheme would be incomplete without specification of penalties, and because, viewed as suggestions only, they might be helpful guides to the States.

It is not believed that there is any general State interest which would lead to a recommendation for the inclusion of a model State act of penalties different than those proposed for Federal offenses. Consequently, it is believed that the penalties proposed for Federal offenses are equally appropriate for parallel offenses under a model State act. In addition, cumulation of punishment for multiple offenses and multiple convictions should be barred to the same extent that they would be barred under the Federal recommendations, and although some second or subsequent dangerous drug offenders may in some States come within the operation of general habitual offender laws, it is not believed that such offenders should be singled out for enhancement of punishment. Further, for the reasons stated in connection with the discussion of Federal penalties, it is not recommended that sales to minors receive any special statutory treatment, that mandatory minimum penalties be adopted or that probation or parole be denied to violators.

However, the misrepresentation and deception offenses proposed for inclusion in a model State act differ from the misrepresentation offense proposed for the Federal Government and, therefore, require independent discussion. In substance, it was proposed earlier herein that a model State act should prohibit a person from unlawfully obtaining or attempting to obtain a controlled drug by (1) knowing misrepresentation, deception or subterfuge from persons authorized by law to dispose of such a drug; (2) use of a knowingly forged or altered prescription; or (3) use of a knowingly false name or address on a prescription. These offenses are designed to vindicate an interest in protecting persons in the legitimate chain of distribution from conduct designed to cause them unwittingly to distribute controlled drugs for illegitimate purposes. Because of this, these offenses are designed to reach small diversions as well as large. Being concerned with small diversions, it is recommended that they should be misdemeanors punishable by a maximum term of imprisonment that is at most no longer than 1 year and by a fine. A misdemeanor should be sufficient to vindicate the interest in protecting the integrity of the system of distribution from the proscribed conduct. It is recommended, however, that when these offenses are committed to facilitate large diversions they should be felonies. This may be done by providing that each of the three basic deception offenses outlined above for inclusion in a model State act should constitute a felony if done with a purpose to sell or otherwise dispose of the drug sought or obtained. Deception for distribution will usually involve fairly large quantities.

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[418] For discussion of the proposed requirements for better availability of records, report of theft or loss and initial inventories of newly designated drugs, see the comments to the Federal recommendations.

[418a] See note 111 *supra*.

[419] Uniform Narcotic Drug Act, § 20.

[420] Model State Drug Abuse Control Act, § 5.

[421] Model State Barbiturate Act, § 7.

[422] Printed in 9 Crime and Delinquency 339-369 (1963).

This scheme would also result in mitigation, though not exoneration, for users who use techniques of deception to obtain drugs for their own use, and consequently, are less culpable and dangerous than persons who use such techniques to obtain drugs for distribution. There would seem to be no reason why the penalty for these aggravated offenses should differ from the maximum penalty proposed for the somewhat similar Federal offense and the aggravated Federal offenses which have been proposed.

Like the Federal deception offense, these offenses should not be within the proposed bar on multiple convictions for multiple offenses relating to a single distribution. However, cumulation of punishment for a deception offense and another offense relating to the same distribution would be inappropriate.

INJUNCTIONS

It is desirable that State authorities have the power to seek injunctions to restrain violations in situations where criminal action is deemed ineffective or otherwise unwarranted or in situations where restraint as well as criminal action is deemed warranted. The Federal district courts are given authority to issue restraining orders and injunctions to restrain violations of the Federal Food, Drug, and Cosmetic Act.[423] A similar provision is included in the Model State Drug Abuse Control Act.[423a]

OTHER PROVISIONS

Provisions relating to seizure, condemnation, the power to make arrests, and to carry firearms similar to those in the 1965 Federal amendments should be included in a model State act. Such provisions are necessary to effective enforcement of the provisions of the act. Provisions for seizure and condemnation are particularly significant as they enable enforcement agencies to reduce the supply of controlled drugs in illicit channels.

Specific provision should be made to give the enforcement agency the power to make rules and regulations under the act.[423b]

For the following, see the discussion under the comments to the Federal recommendations:

Availability of records, reports of theft or loss, initial inventories of newly designated drugs,
Practitioners' exemption from recordkeeping requirements,
Prescription limitations,
Discretion of practitioners,
Use and possession offenses,
Unauthorized manufacture,
Misrepresentation and deception provisions.

PART II: MARIHUANA (CANNABIS)

RECOMMENDATIONS

1. Both the Federal Government and the States should regulate marihuana like other dangerous drugs rather than like narcotics. The Federal Government should regulate it under the Drug Abuse Control Amendments, and the States should control it under dangerous drug laws essentially based on the Federal amendments and the proposals herein.

2. Neither use nor simple possession of marihuana should be the subject of criminal prohibition by either the Federal Government or the States. Even if marihuana is not to be regulated under the Federal drug abuse control amendments, possession with intent to sell or otherwise dispose of it should be a Federal crime, but 26 U.S.C., section 4744(a), prohibiting obtaining or otherwise acquiring the drug without paying the transfer tax and providing that proof of possession coupled with failure after reasonable demand to produce a written order is "presumptive evidence of guilt", should be repealed.

3. Both Federal and State penalties for offenses relating to marihuana should be the same as penalties for offenses relating to other dangerous drugs. Existing mandatory minimum penalties and restrictions on probation, suspended sentences and young adult treatment should be repealed.

COMMENTS

The Drug—Effects and Dangers

As is the case with other dangerous drugs, existing knowledge concerning such matters as the effects of marihuana on the individual, the types of persons who use it, and the relationship of use to crime is not complete. However, such information as is available indicates that there is a great gap between the known facts and risks of marihuana use and the reputed facts and risks.[424] Professor Blum's report to the Commission, which was based on a review of primary studies and secondary literature, makes this clear.[425] Professor Blum points out that some law enforcement officials attribute violent, reckless, or impulsive crime to marihuana.[425a] Also, marihuana has been associated with use of and addiction to narcotics, because some heroin users have had prior marihuana experience. There is probably a tendency not only to associate marihuana use with heroin use but to assume it is as dangerous or has the same effects as heroin.

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[423] Sec. 302, 21 U.S.C., § 332.

[423a] Model Drug Abuse Control Act, § 3.

[423b] Such a provision is contained in § 9 of the Model State Drug Abuse Control Act.

[424] Blum Report at 20.

[425] See Id., at 11-20.

[425a] Blum Report at 12.

Although marihuana is treated as a narcotic under many State laws and in the same manner as "hard" narcotics by Federal law, it is not a narcotic.[426] The Subcommittee on Narcotics Addiction of the Public Health Committee of the New York County Medical Society has called it "a mild hallucinogen".[427] As stated before, this is in contrast to peyote which the society has called a "moderately potent hallucinogen" and LSD which it has characterized as a "highly potent hallucinogen." [428] The use of the term "hallucinogen" as applied to marihuana may not be completely accurate, however, because although its effects like those of other drugs will depend on the user and the time and circumstances of use, Professor Blum, in his report to the Commission points out that "it seems more likely to produce intoxicating effects similar to alcohol" than hallucinations.[429] Apparently use does not lead to physical dependence.[430] Of course, as with almost anything it could lead to psychological dependence. However, Professor Blum states "that in the United States neither cannabis psychosis nor cannabis dependency has been described, although marihuana may be one of a variety of drugs used in the 'multihabituation' pattern (where a person takes many different drugs and appears dependent, but not on any one of them)." [431] Although pointing out that more study is needed, he also states that "the best estimate is that experimentation is far more common than regular use and that heavy use (as occurs in Africa and Asia) is quite rare." [432] The New York County Medical Society suggests that "the number of habitual users * * * in our college population is small." [433] The society further states that "there are very few marihuana smokers * * * in the United States" "who use large amounts for prolonged periods of time." [434]

Most investigators and reporters agree that in the United States there is not "reliable evidence that marihuana 'causes' crime." [435] Of course, where acquisition, use, possession (which may well be for use), or disposition of marihuana are crimes, marihuana may be said to cause these crimes. The New York County Medical Society states that "there is no evidence that marihuana use is associated with crimes of violence in the United States." [436] However, the society does point out that:[437]

> as a hallucinogen * * * it can, in some persons, under certain circumstances, produce all the untoward effects attributed to more potent hallucinogens, including aggressive behavior and psychosis * * * marihuana users frequently have impaired judgment in certain areas, particularly in skilled activities, such as driving.

In "The Cannabis Habit: A Review of Recent Psychiatric Literature," Prof. H. B. M. Murphy of the department of psychiatry of McGill University of Montreal concludes that cannabis smoking:[438]

> * * * probably produces a specific psychosis, but this must be quite rare, since the prevalence of psychosis in cannabis users is only doubtfully higher than the prevalence in general populations.

Professor Murphy also states that although aggressive or antisocial behavior can occur, it "is agreed to be less common with Cannabis than with alcohol",[439] and that "most serious observers agree that Cannabis does not per se, induce aggressive or criminal activities, and that the reduction of work-drive leads to a negative correlation with criminality rather than a positive one." [440] Professor Blum, while not rejecting the possibility that marihuana users may have impaired driving skills while under the influence of the drug, indicates that additional study on the point is in order.[441]

The New York County Medical Society also emphasizes that some of the confusion regarding the dangers of marihuana is caused by a failure to recognize the different potencies of Cannabis.[442] It states that Indian charas and hashish are quite potent and that habitual use (which it describes "an average of at least 6–10 cigarettes per day) has been associated with criminality, violence, and admission to mental hospitals for psychosis." [443] The marihuana used in the United States as well as other less potent forms used in India and North Africa, it points out, are by contrast far less potent, being perhaps one-fifth the strength of hashish and "are far less dangerous".[444] The society's report further states "that criminality and violence have not been correlated with these less potent forms and cannabis-induced psychoses for the most part occur only among those who use large amounts for prolonged periods of time", and "there are very few marihuana smokers in this category in the United States." [445] Even in Africa where more potent forms of Cannabis are used it has been questioned whether crime is due to the use of the drug or whether the user is a criminal because of other complex factors.[446]

The relationship of marihuana use to heroin use also needs examination. While apparently a large number of heroin users have used marihuana at one time or another, it appears that only a small number of persons with marihuana experience become heroin addicts. While the new York County Medical Society reports that "It is true that over 50 percent of heroin users have had prior marihuana experience,"[447] it points out:[448]

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[426] N.Y. C'ty Med. Soc'y Report, 22 N.Y. Medicine, No. 9, 3 (May 5, 1966).

[427] Id., at 4.

[428] Ibid.

[429] Blum Report at 5.

[430] N.Y. C'ty Med. Soc'y Report, 22 N.Y. Medicine, No. 9, 3 (May 5, 1966); Murphy, "The cannabis habit: a review of recent psychiatric literature," 16 Bulletin on Narcotics, No. 1, 15, 17, 19, 22 (January–March 1963) (hereinafter "Murphy").

[431] Blum Report at 13.

[432] Id., at 12.

[433] N.Y. C'ty Med. Soc'y Report, 22 N.Y. Medicine, No. 9, 3 (May 5, 1966) (first emphasis in original; second emphasis supplied).

[434] Ibid.

[435] Blum Report at 13; N.Y. C'ty Med. Soc'y Report, note 433 supra; Murphy at 16; Mayor's Committee on Marihuana (New York City), The Marihuana Problem in the City of New York; Sociological, Medical, Psychological and Pharmacological Studies 214 (1944) (hereinafter "La Guardia Report").

[436] N.Y. C'ty Med. Soc'y Report, note 433 supra, at 3.

[437] Ibid.

[438] Murphy at 22.

[439] Id., at 16.

[440] Ibid.

In contrast, in Munch, "Marihuana and crime," 18 Bulletin on Narcotics, No. 2, 16 (April–June 1966) the author concludes that "literature surveys and personal contacts have clearly demonstrated the association between the use of marihuana and the commission of various crimes." He in part bases his conclusion on a review of cases from law enforcement files where crime (of various types) was apparently committed "after use, and under influence, of marihuana." Id., at 18. Skeletal accounts of "representative" cases are included. Id., at 18–21. It is unclear to the author of this report whether in these cases the person charged was under the influence of the drug (and, if so, to what extent) at the time of the criminal act or whether he was merely a user. In either event it is extremely questionable whether such data throws any light on the relationship between marihuana and crime, other than to show that: (*a*) some marihuana users or (*b*) some marihuana users while under the influence of the drug, have committed some crimes. It does not tell us why they did so (i.e., whether these persons would have been likely to commit crime if they were not under the influence of the drug or were not users) or whether the estimated size of the group of marihuana users or persons under the influence of the drug who do commit crime (other than the acquisition, use, simple possession or disposition of marihuana itself) is significant or insignificant compared to the estimated size of the marihuana-using population.

[441] Blum Report at 14.

[442] N.Y. C'ty Med. Soc'y Report, 22 N.Y. Medicine, No. 9, 3 (May 5, 1966).

[443] Ibid.

[444] Ibid.

[445] Ibid.

[446] Blum Report at 13–14.

> But among the hundreds of thousands of persons who have had one or a few marihuana experiences, only a small number subsequently become heroin addicts.

Professor Blum, reviewing the literature, states that "the evidence is clear that many persons not in heroin-risk neighborhoods who experiment with marihuana do not 'progress' to 'hard' narcotics."[449] He also points out that although case studies "suggest that many identified heroin users have had earlier experiences with marihuana," they are also likely to have had "even earlier illicit" experience with cigarettes and alcohol.[450]

Existing Law

At both the Federal and State level marihuana is controlled in a manner similar to heroin and other "hard narcotics". Federal control is via the taxing power, and a transfer tax and an occupational tax are prescribed by the Marihuana Tax Act.[451] All persons dealing in marihuana must register with the Bureau of Narcotics and pay an occupational tax.[452] The act requires registrants, whenever required to do so by the Secretary of the Treasury or his delegate, to render information returns, verified by affidavit, for "such period immediately preceding the demand of the Secretary * * *, not exceeding 3 months, as the Secretary * * * may fix and determine."[453] Returns are to set forth the quantity harvested, or, if received from another, the persons from whom received and the date and quantity of each receipt.[454] The great number of transfers are taxable and must be made pursuant to official written order.[455] The transferee must obtain an official written order form from the Bureau of Narcotics.[456] One copy is preserved by the Bureau, the original is to be given by the transferee to his transferor, and the transferee is to keep the second copy.[457] Both the original and transferee's copy are to be retained and made available for inspection for 2 years.[458] The written order requirement is inapplicable to transfers by registered practitioners to patients "in the course of * * * professional practice only."[459] The practitioner, however, is to maintain records of each such transfer and keep them available for inspection for 2 years.[460] Similarly, transfers made in good faith pursuant to written prescriptions of registered practitioners are also exempted from the written order requirement.[461] Again, the prescription is to be retained for inspection for 2 years.[462]

The transfer tax applies to all transfers except certain transfers of seeds, certain transfers to Federal, insular, State and local officials, legitimate exportations and transfers connected with medical use (including prescriptions) "in the course of professional practice only."[463]

Criminal offenses closely parallel those dealing with narcotics. The Narcotic Drug Import and Export Act prohibits knowing unlawful importation with intent to defraud the United States and the receipt, concealment, purchase, or sale of unlawfully imported marihuana with knowledge of unlawful importation.[464] Unexplained possession is sufficient to convict under this section as it is in the case of narcotics.[465]

The Marihuana Tax Act (as amended) prohibits interstate delivery, shipment and transportation but exempts certain classes of persons.[466] These classes include registrants who have paid the occupational tax and their employee (when acting within the scope of their employment), contract carriers acting for such registrants, common carriers, persons delivering marihuana prescribed by a registered practitioner for a particular patient, patients who have obtained marihuana either directly from a registered practitioner in the course of his professional practice and for legitimate medical purposes or pursuant to a written prescription issued for legitimate medical purposes and Federal, insular, State and local officials acting within the scope of their official duties.[467] The act also prohibits persons required to register and pay the occupational tax from importing, manufacturing, producing, dealing in, compounding, prescribing, administering, dispensing, selling, or giving away marihuana without having registered and paid the tax;[468] where a written order is required, the act forbids transferors to make transfers without one;[469] and prohibits acquiring or otherwise obtaining the drug without having paid the transfer tax.[470] Possession coupled with failure after reasonable notice and demand by the Bureau of Narcotics to produce the original written order are "presumptive evidence of guilt" of unlawful acquisition.[471]

Penalties are the same as for violations involving narcotics and are harsh.[472] Particularly long sentences are prescribed for sales to juveniles.[473] Mandatory minimum terms of imprisonment are prescribed for all Federal marihuana offenses.[474] In addition, as in the case of narcotics, neither probation, suspended sentence,[475] nor young adult treatment.[476] are available for violation of the illegal importation and written order provisions. In the case of other violations they are not available after the first offense.[477] Under a law enacted in November 1966 violators of the Federal marihuana laws are made eligible for parole.[478] Previously, violators of the illegal importation and written order provisions were ineligible for parole[478a] and violators of other provisions were not eligible for parole after the first offense.[478b]

Marihuana is included as a narcotic under the Uniform Narcotic Drug Act which is either in whole or in part the basis of narcotics regulation in 48 States.[479] State penalties for marihuana violations are often severe.[480] Often, statutes make no distinction between penalties for marihuana violations and penalties for violations relating to narcotics.

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[447] N.Y. City Med. Soc'y Report, note 442 *supra*, at 4.

[448] Ibid; Winick, "Narcotics addiction and its treatment," 22 L. & C.P. 9, 13 (1957). See also LaGuardia Report.

[449] Blum Report at 13.

[450] Ibid.

[451] 26 U.S.C., §§ 4741–62. The act was originally enacted in 1937. Act of Aug. 2, 1937, 50 Stat. 551, 75th Cong., 1st sess.

[452] 26 U.S.C., § 4751 (imposition of tax); 26 U.S.C. § 4753 (registration).

[453] 26 U.S.C., § 4754.

[454] Ibid. Regulations under the act contain detailed provisions as to information returns. 26 CFR, §§ 152.91–99.

[455] 26 U.S.C., §§ 4741(a), 4742.

[456] 26 U.S.C., § 4742.

[457] 26 U.S.C., § 4742(d).

[458] Ibid. The transferee is liable for the transfer tax, but if the transfer is not pursuant to a written order and without payment of the tax, the transferor is also liable. 26 U.S.C., § 4741(b).

[459] 26 U.S.C., § 4742(b)(1).

[460] Ibid.

[461] 26 U.S.C., § 4742(b)(2).

[462] Ibid.

[463] 26 U.S.C., §§ 4741(a), 4742(b).

[464] 21 U.S.C., § 176a.

[465] 21 U.S.C., § 174 (narcotics).

[466] 26 U.S.C., § 4755(b).

[467] Ibid.

[468] 26 U.S.C., § 4755(a).

[469] 26 U.S.C., § 4742(a).

[470] 26 U.S.C., § 4744(a).

[471] Ibid.

[472] 26 U.S.C., § 7237.

[473] 26 U.S.C., §7237(b).

[474] 26 U.S.C., § 7237 (a), (b).

[475] 26 U.S.C., § 7237(d)(1).

[476] Public Law 87–752, § 7, 72 Stat. 847, 85th Cong., 2d sess. (1958).

[477] 26 U.S.C., § 7237(d)(2) and Public Law 87–752, § 7, 72 Stat. 847, 85th Cong., 2d sess. (1958).

[478] Public Law 89–793, title V, § 501, 80 Stat. —, 89th Cong., 2d sess. (Nov. 8, 1966). The bill as passed is printed at 112 Congressional Record 26608, 26612 (House) (daily ed. Oct. 19, 1966) (H.R. 9167). Sec. 501 amends 26 U.S.C., § 7237(d).

[478a] 26 U.S.C., § 7237(d)(1) (1964 ed.).

[478b] 26 U.S.C., § 7237(d)(2) (1964 ed.).

The Regulatory Scheme

It is recommended that both Federal and State law should regulate marihuana like any other dangerous drug rather than like hard narcotics. On the Federal level it should be regulated under the Drug Abuse Control Amendments, and after Federal action to this end, it should be controlled by the States under dangerous drug laws essentially based on the Federal amendments and the proposals herein. Thus, the regulatory requirements of the amendments and of similar State laws would be applicable to marihuana, and manufacture (including cultivation), disposition, and possession with intent to dispose would be criminal offenses. Penalties would correspond to penalties for other violations of the Drug Abuse Control Amendments and of State acts based upon it. For reasons stated in the following section of this report neither simple possession nor use would be punishable.

The reasons which support regulation of other hallucinogens under a law like the 1965 Federal act also support similar regulation of marihuana.[481] While Cannabis does not have any significant nonexperimental medical use in the United States, it does have some limited medical use in other parts of the world—especially in folk medicine—[482] and it cannot be said with any certainty that it will never have significant medical use in this country.[483] Furthermore, since the marihuana in illicit use in this country is largely either cultivated illicitly or smuggled into the United States, it is questionable whether the current narcotic-like system of regulation is any more effective in controlling marihuana traffic than the system of regulation embodied in the drug abuse control amendments would be.

It is not believed that the dangers of marihuana support the current narcotic-like system of regulation. While the dangers of the drug are not negligible, it should be recognized that marihuana is not a particularly dangerous drug. It is in many respects the least dangerous of the drugs discussed in this report; it is much less dangerous than LSD. Nor is it believed that the relationship between marihuana and heroin use makes marihuana sufficiently dangerous to warrant the current system of regulation. Regardless of the significant number of heroin addicts in the United States who have a history of marihuana use, it remains that to our knowledge only a relatively small number of persons with marihuana experience become heroin addicts. Nor would there seem to be any need to use the taxing power as the basis of regulation. The taxing power has no inherent benefit over the commerce power as a vehicle for regulation.[484] In fact, a comparison of the 1965 Drug Abuse Control Amendments with the Federal narcotics and marihuana laws indicates that regulation under the commerce clause can be less cumbersome than regulation under the taxing power, because there is no need to tie regulation to any tax.[485]

Use and Possession Offenses

Simple possession of marihuana is prohibited in virtually every State, and some States prohibit use also.[486] The Federal Marihuana Tax Act in prohibiting a transferee required to pay the transfer tax from acquiring or otherwise obtaining marihuana without having paid the tax, provides that proof of possession combined with failure after notice and demand from the Bureau of Narcotics to produce a written order "shall be presumptive evidence of guilt * * *.[487] Also, possession of marihuana is by statute deemed "sufficient evidence to authorize conviction" under the illegal importation provision of the Narcotic Drug Import and Export Act "unless the defendant explains his possession to the satisfaction of the jury." [488]

It is recommended that neither simple possession nor use of marihuana should be treated criminally.

Marihuana does have a potential for abuse. Consequently, it should be controlled, distribution prohibited, and use discouraged. It is not believed, however, that the possible dangers of use are great enough to make it necessary to use the criminal law to condemn the marihuana user solely for his use. As in the case of other dangerous drugs, society can condemn and discourage use by sanctions on trafficking (including possession with a purpose to sell or otherwise dispose) and by educational efforts.

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[479] See 9B Uniform Laws Annotated, 1964 Supplement at 110. The exceptions are California and Pennsylvania. Legislation in some States is only in part based on the act. Also, there have been varying amendments in a number of other States. Consequently, the law in those States having legislation based on the act is not entirely uniform.

[480] E.g., Ala. Code title 22, § 258 (1958) (possession and sale: First offense, 5 to 20 years and not more than $20,000; subsequent offenses, 10 to 40 years and not more than $20,000); Ark. Stat. Ann., § 82-1020 (Supp. 1965) (possession and sale: First offense, 2 to 5 years and not more than $2,000; second offense, 5 to 10 years and not more than $2,000; subsequent offenses, 10 to 20 years and not more than $2,000); Ind. Ann. Stat., § 10-3538 (Supp. 1966) (sale: First offense, 5 to 20 years and not more than $2,000; subsequent offenses, 20 years to life and not more than $5,000) (possession: First offense, 2 to 10 years and not more than $1,000; subsequent offenses, 5 to 20 years and not more than $2,000); Me. Rev. Stat. Ann., ch. 22, § 2380 (1964) (possession and sale: First offense, 2 to 8 years and not more than $1,000; second offense, 5 to 15 years and not more than $2,000; subsequent offenses 10 to 20 years and not more than $5,000); Md. Ann. Code, art. 27, § 300 (Supp. 1965) (possession and sale: First offense, 2 to 5 years and not more than $1,000; second offense, 5 to 10 years and not more than $2,000; subsequent offenses, 10 to 20 years and not more than $3,000); Okla. Stat. Ann., title 63, § 452 (1961) (possession and sale: Not more than 7 years and not more than $5,000); Pa. Stat. Ann., title 35, § 780-20 (c), (d) (1964) (possession: First offense, 2 to 5 years and not more than $2,000; second offense, 5 to 10 years and not more than $5,000; subsequent offenses, 10 to 30 years and not more than $7,500) (sale: First offense, 5 to 20 years and not more than $5,000; second offense, 10 to 30 years and not more than $15,000; subsequent offenses, maximum of life imprisonment and not more than $30,000).

[481] See text at notes 189-192, *supra.*

[482] Murphy at 20, 21, 22; Chopra and Chopra, "The use of the cannabis drugs in India," 9 Bulletin on Narcotics, No. 1, 4, 9-10 (January-March 1957); Kabelik, Krejci and Santavy, "Cannabis as a medicament," 12 Bulletin on Narcotics, No. 1, 5, 22 (July-September 1960). See also Fort, "Social and legal response to pleasure-giving drugs" in Blum (ed.), Utopiates 205, 214 (1964).

[483] At one time cannabis was more used in Western medicine than it is at present. See Chopra and Chopra, supra at 9. However, even today research into its antibiotic effect is being conducted in Eastern Europe, Murphy at 20 and sources cited; *Kabelik et al.*, supra.

On more than one occasion substances used in folk medicine have later been found to have pharmacological effects useful in modern medicine. An example is Rauwolfia serpentina (Indian snake root). Goodman and Gilman state that medical use of plants resembling rauwolfia appears in ancient Hindu writings. These plants had a number of uses in primitive Hindu medicine. Goodman and Gilman, The Pharmacological Basis of Therapeutics 178 (3d ed. 1965). Today rauwolfia alkaloids are used in the treatment of some psychotic patients and in the treatment of hypertension. Id., at 178—82, 569-72.

The President's Advisory Commission on Narcotic and Drug Abuse recommended that marihuana be regulated in a manner different than that proposed herein. It recommended the outright prohibition of importation, production, and sale and other transfers except where expressly licensed by the Secretary of Health, Education, and Welfare for legitimate scientific purposes or for the emergency production of hemp. The President's Advisory Commission on Narcotic and Drug Abuse, Final Report 36-37 (1963). The prime reason for this recommendation was the Commission's adoption of the view of the Commission on Narcotic Drugs of the United Nations Economic and Social Council, that marihuana appears to have no beneficial effects in modern medicine. Id., at 36.

[484] Use of the taxing power as the basis of Federal narcotics and marihuana regulation was justifiable when the Harrison Act and the Marihuana Tax Act, respectively, were enacted. When the former was enacted the commerce power was not broad enough to support such regulation; when the latter was enacted it was doubtful whether it was broad enough. Today, the commerce power is presumably broad enough to support such regulation. See *Heart of Atlanta Motel, Inc.* v. *United States*, 379 U.S. 294 (1964); *Katzenbach* v. *McClung*, 379 U.S. 294 (1964).

[485] The occupational and transfer taxes under the Marihuana Tax Act like the similar taxes on narcotics under the Federal narcotics laws are actually not designed for revenue purposes, but are merely the basis for regulation. Cf., Note, "Consecutive sentences in single prosecutions: judicial multiplication of statutory penalties," 67 Yale L.J. 916, 927 and n. 39 (1958) (narcotics).

[486] E.g., Ariz. Rev. Stat. Ann., § 36-1062 (Supp. 1966) ("use, or be under the influence of"); Calif. Health and Safety Code, § 11721 ("use or be under the influence of"); Pa. Stat. Ann., title 35, § 780-4(r) (1964) ("using, taking, administering to the person, or causing to be administered to the person, or administering to any person or causing to be administered to any other person").

[487] 26 U.S.C., § 4744(a).

[488] 21 U.S.C., § 176a.

Should the marihuana user engage in crime, be it distribution of marihuana, heroin or any other dangerous drug, or any other crime, he should, of course, be subject to punishment for his conduct like any other offender.

As stated previously, marihuana is in many respects the least dangerous of the drugs considered in this report. "There is no reliable evidence marihuana 'causes' crime."[489] Apparently, most use is experimental. Use does not lead to physical dependence. The problems of greatest concern would be marihuana psychosis and the likelihood that exposure to marihuana will lead to heroin addiction. The former has not been described in the United States, because it usually occurs among those who have used large amounts for long periods of time, and there are few such users in the United States. And, again, despite the number of heroin addicts who have had marihuana experience, apparently relatively few persons with marihuana experience become heroin addicts.

One can only speculate as to what the effects of abandoning restrictions on simple possession and use while retaining restrictions on trafficking might be. As in the case of other drugs discussed in this paper, presumably use and simple possession offenses deter some persons,[490] have no impact on others, and affirmatively attract an unknown number of persons to the use of marihuana.[491] It is possible that if these restrictions were lifted use might increase at least temporarily; to what extent one cannot say. But if the persons society most desires to deter are those who are likely to engage in habitual use (because they are the persons most likely to suffer psychosis) and those most likely to become heroin addicts or to become dependent on other drugs, it should be asked whether repeal of simple possession and use provisions would lead to use by large numbers of persons who are likely to go on to habitual use or to become heroin addicts or dependent on other drugs, and who are not using marihuana today? To put it another way, are current restrictions on possession and use more likely to deter those persons most likely to become habitual users of marihuana, heroin addicts, or dependent on other drugs than they are to deter persons who would not be likely to become habitual users or dependent on heroin or other drugs if they were to try marihuana? Is it possible that we are in general deterring persons who would be no more than experimental users? We can only speculate. But it is questionable whether these restrictions are a significant deterrent to use by the persons whom society most desires to deter. Persons likely to become habitual users or go on to use of another drug would seem to be the persons most likely to use marihuana despite them. If this is so, would it be reasonable to anticipate large numbers of new habitual users or a large increase in use by persons likely to become dependent on heroin or other drugs, if simple possession and use were no longer to be subjects of criminal treatment?

In short, the dangers of marihuana do not support the criminal treatment of the user solely for his use. Criminal treatment would seem to be particularly inappropriate for the relatively young experimental user, and probably there are many American users in this group.[492] In this light, the possibility that repeal of existing prohibitions on simple possession and use might increase use is not deemed sufficient reason for retaining them, especially when it is far from clear that lifting these restrictions would lead to a large increase in habitual use or in use by persons likely to become dependent on heroin or other drugs. Of course, a prohibition on simple possession of marihuana also presents, insofar as it is directed at ultimate distribution, the problem encountered earlier herein of a prohibition on conduct which is ambiguous in relation to ultimate distribution and which creates strict liability as to whether that conduct was directed to distribution.

It is not believed the possibility that marihuana may impair driving skills warrants a contrary conclusion. Before any such conclusion might be justified at the very least information as to the size of the group which is likely to drive under the influence of the drug would be in order. However, even though there is currently no chemical test by which it is possible to determine whether a person is under the influence of marihuana, State statutes prohibiting driving under the influence of the drug or, preferably, making such conduct a ground for suspension of an operator's license might not be inappropriate.

Patterns of distribution of marihuana may differ from patterns of distribution of "medically depressant or stimulant drugs" in the sense that there may be some reason to believe that suppliers of large amounts play a less significant role in domestic distribution of marihuana than they do in illicit distribution of "medically depressant or stimulant drugs." Consequently, it is possible that it may be more difficult to cut down the supply of marihuana by law enforcement—whether it be enforcement of laws prohibiting trafficking or of laws prohibiting possession or use—than to cut down the supply of illicit "medically depressant and stimulant drugs" by these means. On the other hand, there is no reason to believe that detection and conviction of individual traffickers for violation of laws against trafficking is more difficult where marihuana is involved than where other drugs are involved. In fact, because there are few large users of marihuana in the United States, it will probably be easier to use quantity to prove that possession was for sale or disposition, and not for personal use than it will be in the case of "medically depressant or stimulant drugs."

It follows from the recommendation in this section that even if marihuana is not to be included as a "depressant or stimulant drug" under the Drug Abuse Control Amendments, Federal law should prohibit possession of the drug with a purpose to sell or otherwise dispose of it, and 26 U.S.C. section 4744(a) should be repealed.[493] Section 4744(a) prohibits obtaining or otherwise acquiring the drug without paying the transfer tax. Proof of possession coupled with failure after reasonable demand to produce a written order is presumptive evidence of guilt. Insofar as section 4744(a) prohibits unauthorized acquisition, it is believed that the interest in exempting the user from punishment for his use outweighs the interest in punishing him for acquisition. Insofar as a prohibition on acquisition may be directed against later distribution, it presents the same problems as does a direct prohibition on simple possession. So viewed, an acquisition offense reaches conduct which is even farther back in time than does a possession offense.

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[489] Blum Report at 13.

[490] The President's Advisory Commission on Narcotic and Drug Abuse questioned the deterrent effect of marihuana laws on the user. "* * * it is difficult to believe * * * that a marihuana user obsessed by the 'high' sensation of marihuana will think of the penalty that awaits him if he is caught possessing it." The President's Advisory Commission on Narcotic and Drug Abuse, Final Report 40 (1963). The deterrent effect of marihuana laws on use may well be questioned.

[491] In his report to the Commission Professor Blum states: "Some users interviewed recently argue that they have chosen to smoke 'pot' *because* the laws are so patently inappropriate and they wish to signify their disapproval through direct disobedience." Blum Report at 15 [emphasis in original].

[492] Blum Report at 12–13.

[493] Problems relating to the presumption flowing from possession under 21 U.S.C., § 176a—which prohibits knowing importation of marihuana, as well as concealing, buying, selling, and facilitating the transportation, concealment or sale of marihuana, knowing it to have been illegally imported—are beyond the scope of this study.

Should the Commission be of the opinion that prohibitions against either use or simple possession of marihuana are desirable, it is recommended that it endorse the concept of the precharging conference and that it recommend that use, simple possession, and acquisition should be treated either as civil violations carrying no possibility of deprivation of liberty, or, at most, as misdemeanors. At the very least, mandatory minimum sentences and restrictions on probation and young adult treatment for use, simple possession, and acquisition offenses should be abolished.

The verified dangers of marihuana use do not warrant the harshness with which we presently treat the user—or even the seller.

Mandatory Minimum Penalties and Prohibitions on Probation and Parole

The undesirability of mandatory minimum sentences for narcotics offenses and of measures making probation, suspended sentences, parole, and young adult treatment unavailable for narcotic offenders have been discussed in Professor Aronowitz's report to the Commission.[494] The propriety of these measures for "depressant or stimulant drug" offenses was discussed earlier herein.[495] Little need be added to these discussions. What is of special significance is that the dangers of marihuana do not warrant any of these measures either for the seller or the user. If mandatory penalties and the other measures under discussion are ever appropriate, they should be limited to serious offenses. They are patently inappropriate to violations of the marihuana laws. Both the President's Advisory Commission on Narcotic and Drug Abuse and Senator Kennedy of New York criticized mandatory minimum sentences and prohibitions on probation and parole for marihuana offenders. In its final report the Commission stated:[496]

> This Commission makes a flat distinction between the two drugs [opiates and marihuana] and believes that the unlawful sale or possession of marihuana is a less serious offense than the unlawful sale or possession of an opiate.
>
> The Commission believes that the sentencing of the petty marihuana offender should be left entirely to the discretion of the Federal courts. There should be no mandatory minimum sentences for marihuana offenders and no prohibition of probation and parole. The courts should have the discretion to impose a fixed maximum sentence (with eligibility for parole), to suspend sentence, or to impose an indeterminate sentence. The Commission is opposed to mandatory minimum sentences, even in the case of multiple offenders.

Senator Kennedy, of New York, testifying in support of a bill that would have eliminated mandatory minimum sentences and permit probation, parole and (where they are otherwise eligible) young adult treatment for marihuana offenders, said:[497]

> I certainly do not mean to suggest that there is anything good about the use of marihuana or the trafficking in it. But while it is true that the majority of heroin addicts begin on marihuana, it is also true that the vast majority of marihuana users do not go on to use heroin. So many of those who use marihuana, while unwise, are not people who are appropriately dealt with by being thrown into jail and having the key tossed away. After careful consideration, the President's Advisory Commission concluded "that the unlawful sale or possession of marihuana is a less serious offense than the unlawful sale or possession of an opiate." I therefore hope that this committee will sympathetically consider eliminating mandatory minimum sentencing for violation of the laws relating to marihuana.

The recent legislation making marihuana violators eligible for parole is desirable. However, mandatory minimum sentences and the other restrictions under discussion are also inappropriate for marihuana violations and should be removed.

PART III: TREATMENT OF USERS OF "DEPRESSANT AND STIMULANT DRUGS" AND MARIHUANA

RECOMMENDATIONS

1. Neither the Federal Government nor the States should enact legislation authorizing the involuntary civil commitment of users of any dangerous drug or drugs (including marihuana) who are neither charged with crime nor under sentence for conviction of a crime.

2. Both the Federal Government and the States, respectively, should permit barbiturate addicts and barbiturate-like CNS depressant drug addicts who are charged with crime but who have not pleaded guilty or been convicted of the charge, to volunteer for civil commitment to a treatment program in lieu of prosecution under the circumstances and procedures proposed with reference to narcotic addicts in Professor Aronowitz' report to the Commission. Civil commitment in lieu of prosecution should not extend to amphetamine, marihuana, or LSD users who are not addicts of barbiturates or barbiturate-like CNS depressants.[497a]

3. Both the Federal Government and the States, respectively, should enact legislation authorizing Federal and State correctional authorities, respectively, to place prisoners who are barbiturate addicts and barbiturate-like CNS depressant drug addicts in a treatment program for a period not to exceed the sentence imposed by the court under the circumstances and procedures proposed by

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[494] Aronowitz Report at 24–27.

[495] Pp. 180–82 supra.

[496] The President's Advisory Commission on Narcotic and Drug Abuse, Final Report 42 (1963).

[497] Testimony of Senator Kennedy of New York before the Senate Judiciary Committee 6 (Jan. 26, 1966). The Senator testified in support of S. 2114, 89th Cong., 1st sess. (introduced on June 9, 1965) of which he was a cosponsor.

[497a] It is anticipated that any user of a drug considered in this report who is also addicted to an opiate will for purposes of treatment be considered as an opiate addict.

Professor Aronowitz with reference to Federal narcotic addict prisoners. It is not recommended that this legislation should apply to amphetamine, LSD, or marihuana users who are not addicts of barbiturates or CNS depressants.

4. Both the Federal Government and the States should enact legislation permitting barbiturate addicts, barbiturate-like CNS depressant drug addicts, and amphetamine-dependent persons who are neither charged with crime nor under sentence of conviction for crime, to voluntarily commit themselves to a treatment program under the circumstances and procedures recommended by Professor Aronowitz for voluntary civil commitment of narcotics addicts. It is not recommended that this legislation should apply to users of marihuana or LSD who are not barbiturate addicts, barbiturate-like CNS drug addicts or dependent on amphetamines.

COMMENTS

Involuntary Civil Commitment Without Regard to Crime

The reasons which support a conclusion that involuntary civil commitment is inappropriate for narcotic addicts, as set out in Professor Aronowitz's report to the Commission,[497b] apply even more strongly to persons dependent on dangerous drugs. As pointed out earlier in this report,[498] much less is known about the relationship between addiction and habitual use of dangerous drugs to crime, selling and proselytizing than about the relationship between heroin addiction and these activities. In the current state of knowledge involuntary civil commitment for dangerous drug users is unthinkable.

Civil Commitment in Lieu of Prosecution

It is recommended that barbiturate addicts and addicts of barbiturate-like CNS depressants who have been charged with crime should be eligible for voluntary civil commitment in lieu of prosecution under the circumstances and procedures recommended by Professor Aronowitz with reference to narcotic addicts.[499] Ability to diagnose addiction to such drugs is apparently not a serious problem.[500] It appears that whether a person is addicted to a barbiturate or a barbiturate-like CNS drug can be determined with some certainty.[501] While at present little is known about treatment, experience gained in such programs may help to develop effective treatments and provide information as to the nature of addiction to these drugs and characteristics of users. Because the programs recommended would be in lieu of prosecution and since an accused would have to request admission, it is not believed that the present lack of effective treatment methods is a sufficient reason against their adoption.

Eligibility for such programs should not be unduly restricted. The position taken by Professor Aronowitz with respect to restrictions on eligibility for admission to a similar program for narcotic addicts applies also to restrictions on the eligibility of addicts of barbiturates and central nervous system depressants for admission to such a program. Professor Aronowitz wrote, "With few exceptions, all defendants whose crimes are causally related to their addiction should be eligible for commitment in lieu of prosecution." [502] While it is true that no information has come to the attention of the author as to the extent that barbiturate or CNS drug addicts may sell or commit other crimes in order to support their habits, and apparently there have not been any verified cases of "crimes against person or property occurring because of barbiturate ingestion" [503] or ingestion of CNS depressants,[504] it is by no means clear that some such addicts may not sell or commit crime to support their habits. Of course, violations of use and, in the usual case, simple possession laws by addicts would be causally related to their addiction.

Amphetamine-dependent persons would not be eligible for civil commitment in lieu of prosecution unless they were also barbiturate or CNS drug addicts. The determination whether a person is amphetamine-dependent is not easily made, and diagnosis is apparently not particularly reliable at the present time.[505] Civil commitment to a treatment program may be deemed less onerous than the imposition of a usual criminal sentence. It would be unwise to permit it where diagnosis is not relatively reliable, since persons who may not actually be dependent may erroneously be admitted to the program. When improved diagnostic methods become available amphetamine-dependent persons should be made eligible for civil commitment in lieu of prosecution.

It is not recommended that marihuana or LSD users should be eligible for civil commitment in lieu of prosecution. Marihuana dependency is apparently rare in the United States, and, while we know little about the problem, LSD dependency also appears rare. Under these circumstances, even apart from difficulties of diagnosis, there seems to be no compelling reason why marihuana- or LSD-dependent persons should at the present time be included in legislation authorizing civil commitment in lieu of prosecution.

[497b] Aronowitz Report at 2–12.

[498] See text at notes 272–280, *supra.*

[499] Aronowitz Report at 18–23.

[500] Dr. Jerome Levine of the psychopharmacology branch of the National Institute of Mental Health has informed the author that persons suspected of being barbiturate or barbiturate-like CNS depressant drug addicts may be given large doses of abarbiturate or a barbiturate-like CNS depressant drug in order to determine if they are physically dependent. The procedure is described in Bakewell and Wikler, "Symposium: nonnarcotic addiction: incidence in a university hospital psychiatric ward," 196 J.A.M.A. 710–11 (1966). In persons who are not physically dependent such doses will cause slurred speech and other symptoms of intoxication. They will not produce such symptoms in persons who are physically dependent, because of the development of tolerance ("tolerance is defined as a diminishing effect on the repetition of the same dose of the drug or, conversely, as a need to increase the dose in order to obtain the original degree of effect" AMA: Narcotics Addiction 11).

Of course, in some cases addiction may also be recognized by the appearance of withdrawal symptoms.

It is believed that the administration of test doses as suggested above to a person under a charge of crime should not present any constitutional problem if the results are to be used merely to support his request for voluntary civil commitment in lieu of prosecution or as a basis for determination by correction authorities after he has been convicted and sentenced that he should serve his sentence in a treatment program. Legislation should provide that information obtained as a result of testing or examining the person or obtained from him in the course of an examination should not be admissible in any criminal proceeding against him. No opinion is expressed as to whether or not such information should be admissible against him in civil proceedings.

[501] See Bakewell and Wikler, note 500 supra at 710–11.

[502] Aronowitz report at 20. Professor Aronowitz states "The exceptions should be limited to defendants charged with the most serious offenses (perhaps only those carrying maximum terms of life imprisonment or death) and to recidivists whose criminal activities are not principally related to their addiction." Ibid. It is not believed the exceptions for barbiturate and CNS depressant drug addicts should be any more extensive than these.

[503] Blum report at 55.

[504] Id., at 49.

[505] Dr. Jonathan Cole of the Psychopharmacology Research Branch of the National Institute of Mental Health has informed the author that since amphetamines probably do not lead to physical dependence, some arbitrary standard would probably be required to determine whether a person is amphetamine dependent. He stated that a dosage in excess of 50 milligrams daily has been spoken of as an appropriate standard. He further stated that the determination whether a person exceeded such a dosage would be based on the person's history and medical opinion evaluating the patient. Although urine tests by which amphetamine use can be monitored do exist, Dr. Cole did not believe that they were quantitatively accurate.

Dr. Jerome Levine of NIMH has informed the author that persons charged with crime who are suffering from amphetamine psychosis can, like other persons suffering from amphetamine psychosis, probably be effectively treated for the psychosis in conventional psychiatric facilities.

Treatment After Conviction

It is recommended that correctional authorities should be permitted to place barbiturate and barbiturate-like CNS drug addict prisoners in a treatment program for a period not to exceed the sentence imposed by the court in accordance with Professor Aronowitz' recommendation for Federal narcotic addict prisoners.

This recommendation parallels the recommendation for voluntary civil commitment in lieu of prosecution for addicts who are charged with crime but who have not pleaded guilty or been convicted of the charge, and the discussion accompanying that recommendation applies to it also. Eligibility should be as broad as eligibility for civil commitment in lieu of prosecution.[506] Because certain aspects of the program outlined by Professor Aronowitz may be less onerous than service of a sentence outside of the program, it is not recommended, given the unreliability of present methods of diagnosing amphetamine dependence, that persons solely dependent on amphetamines should be eligible for admission to such programs. For reasons suggested earlier, neither LSD nor marihuana users should be eligible.

It is also recommended, however, that Federal and local correctional authorities respectively, should be permitted to designate as a place of confinement for any user (whether or not dependent) of any dangerous drug (including marihuana) any institution or other facility which is equipped to provide care and treatment for that user. This recommendation is based on section 7(a) of S. 2114 which was introduced in the first session of the 89th Congress.[507] The purpose of this recommendation is merely to assure that correctional authorities have the power to permit a sentence to be served in a place where care or treatment for the drug user is available. In all other respects the prisoner would be treated like any other prisoner. Neither length of sentence nor eligibility for parole would be affected, except that the user would receive credit toward his sentence for time spent in the facility.

Voluntary Commitment of Non-Criminal Addicts and Dependent Persons

Both the Federal Government and the States should encourage voluntary civil commitment not related to a charge of conviction of crime. The current lack of knowledge about treatment does not suggest that such programs are inappropriate. Rather, it is a compelling reason for the institution of experimental voluntary programs. Encouragement of participation in such programs may well lead to the improvement of treatment and "to valuable information about the characteristics of addicts and addiction." [508]

Amphetamine-dependent persons should be eligible for these programs even if they are not eligible for civil commitment in lieu of prosecution or participation in a treatment program after conviction of crime. Since participation would be voluntary, and applicants would not be under criminal charge or sentence, the possibility of errors in admitting persons to such programs is not a serious objection.

To insure that persons voluntarily under treatment remain in a treatment facility for a meaningful period of time, it would be advisable to allow participation only by persons who consent to stay in a treatment facility for a specified minimum period of time, such as 6 months.[509] They could, of course, be released earlier if the administrators of the program determined that earlier release was desirable. The minimum selected should not be so long as to unduly discourage voluntary admissions.

For the reasons discussed earlier herein it is not recommended that any such programs be instituted for LSD or marihuana users. Not only does dependence on these drugs appear to be rare,[510] but it would appear that users suffering psychotic reactions from them would often be eligible for voluntary hospitalization under conventional public programs for treatment of the mentally ill.[511]

PART IV: INTOXICANT (GLUE) SNIFFING

RECOMMENDATION

It is recommended that at the present time neither the Federal Government nor the States should enact legislation dealing with intoxicant sniffing. Public education and psychiatric referrals should be encouraged.

COMMENTS

There are a number of industrial substances which are on occasion used for an intoxicating effect. Among these are airplane glue, rubber cement, gasoline and paint thinner.[512] Use, usually called "glue sniffing" is called by Professor Blum "volatile intoxicant sniffing." [513] Professor Blum points out that use is quite rare and that most users are school-age children.[514] He further states, however, that some sniffers may be "susceptible to further drug experimentation on a road that may lead to further dependencies," and that both physiological damage and mild dependency can occur.[515] According to his report, although some intoxicated children studied were assaultive or suicidal, violence seems to be rare.[516]

Only five States have legislation expressly directed against intoxicant sniffing.[517] There is no such Federal legislation. The legislation that does exist attempts to control the problem through criminal prohibitions. This legislation is not uniform. Coverage, while similar, is not identical,[518] and the conduct prohibited varies. In three States inhalation for the purpose of inducing intoxication or for a similar purpose is prohibited.[519] One of these States also prohibits use or possession for such a purpose.[520] The fourth State prohibits "use as an inhalant," [521] and the fifth, inhalation of "such excessive quantities * * * as cause * * * intoxication" or other enumerated conditions.[522] In Illinois sales and offers to sell to persons under 17 years of age are prohibited, unless on the written order of a parent or guardian, when the seller knows or has reason to know that the substance is to be used to induce intoxication or a similar condition.[523] In New Jersey sales and offers to sell to any person when the seller has reasonable cause to suspect that the substance will be used for a prohibited purpose are prohibited.[524] Penalties vary from a fine of $5 to $25 for a first offense of inhalation of excessive quantities in Maryland [525] to not more than 1 year's imprisonment or a fine of not more than $1,000 in New Jersey.[526]

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[506] See note 502 and accompanying text, *supra*; Aronowitz report at 16, 20–21.

[507] Sec. 7(a) of S. 2114 (introduced June 9, 1965) would have authorized Federal correctional authorities to designate as the place of confinement of a Federal prisoner who "is a narcotic addict, or is suffering from a mental or physical condition, and might be helped by proper care, treatment, or rehabilitation (including vocational rehabilitation)", "any appropriate institution or other facility of the United States [or any appropriate State institution or facility with which the Director of Prisons had contracted pursuant to § 6(a) of the bill], which is specially equipped to provide such care, treatment, or rehabilitation." When the correctional authorities determined that a person who was so confined "[was] no longer in need of such care, treatment, or rehabilitation, or that his continued confinement therein [was] no longer necessary or desirable", they could transfer the person to another penal or correctional institution to complete his original sentence. The time spent in the special institution or facility was to be considered as part of the term of imprisonment. The sponsors of S. 2114 intended to make dangerous drug users eligible for treatment while serving sentence. See the testimony of Senator Kennedy of New York before the Senate Judiciary Committee on Jan. 26, 1966.

[508] Aronowitz report at 23.

[509] See Aronowitz report at 23–24.

[510] Neither cannabis psychosis nor dependency has been described in the United States. Blum report at 13.

[511] The NIMH report on treatment of narcotic drug addiction for the President's National Crime Commission (revised as of June 6, 1966) states (at 22) that "Abusers of LSD or other hallucinogens who develop psychiatric symptoms (schisophrenic-like or panic reactions) can probably be adequately handled in conventional psychiatric settings."

[512] Blum Report at 59. The New York County Medical Society has called airplane glue a "mild hallucinogen." N.Y. C'ty Med. Soc'y Report, 22 New York Medicine, No. 9, 3, 4 (May 5, 1966).

[513] Blum Report at 59.

[514] Blum Report at 59–60. See also N.Y. C'ty Med. Soc'y Report, note 512 supra, at 5.

[515] Blum Report at 61. Goodman and Gilman state, "The possibility that 'glue sniffing' might cause damage to the hematopoietic system, liver, and kidneys has not been excluded." "The Pharmacological Basis of Therapeutics," 927 (3 ed. 1965).

[516] Ibid.

[517] Hawaii Rev. Laws, § 53.–5.5 (Supp. 1965); Ill. Rev. Stat., ch. 38, § 81–1 (Supp. 1965); Md. Ann. Code, art. 27, § 313A (Supp. 1965); Maine Rev. Stat., ch. 17, § 3475 (Supp. 1966); N.J. Rev. Stat., §§ 2A: 170–25.9–12 (Supp. 1965).

It is not recommended that any State or Federal legislation dealing with intoxicant sniffing be enacted.

Prohibitions on use or on possession with intent to use would seem singularly inappropriate. Intoxicant sniffing apparently occurs rather infrequently, and many of its practitioners are children. Even where adult practitioners are involved it is doubtful whether criminal prohibitions would constitute any deterrent.

Neither is it believed that laws which prohibit sale when the seller knows or has reason to know that the substance which is the subject of the sale will be used for its intoxicating effect serve any significant purpose. Where intoxicating substances are bought over the counter it would seem that it would be very difficult to prove that the seller knew or had reason to know of the buyer's purpose. Older minors and children may purchase some industrial substances which are capable of producing intoxication for legitimate purposes. While the author has not found any supporting statistics, it is probable that children and older minors constitute a large proportion of the market for airplane glue. Older minors and even children may also have a legitimate interest in purchasing such a substance as paint thinner. For these reasons, both an absolute bar on sales to minors under a certain age and a bar on such sales in the absence of written permission of a parent or guardian also would seem inappropriate. Laws requiring purchasers under a certain age to enter their names and addresses in a registry at the time of making a purchase, as purchasers of certain exempt narcotics must, or requiring sellers to otherwise keep a record of the names and addresses of such purchasers are possibilities, but in addition to being burdensome to sellers, it is questionable whether laws such as these would actually accomplish very much.

Given the apparently small dimensions of the problem and the difficulty of controlling it by law, the author recommends, that (1) public education and (2) as recommended by Professor Blum in his report,[527] steps by schools, health agencies, and, when the matter comes to its attention, the police, to refer sniffers to psychiatric personnel are the best methods for dealing with the problem of sniffing.

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[518] Hawaii Rev. Laws, § 53–5.5 (Supp. 1965) ("any substance not a 'food' * * * which substance includes in its composition volatile organic solvents including amylacetate, tricholoroethylene, and acetone or any other chemical substance capable of producing upon inhalation any degree of intoxication"); Ill. Rev. Stat., ch. 38, § 81–1 (Supp. 1965) ("any compound, liquid, or chemical containing toluol, hexane, trichloroethylene, acetone, toluene, ethyl acetate, methyl ethyl ketone, trichoroathane, isopropanol, methyl isobutyl ketone, methyl cellosolve acetate, cyclohexanone, or any other substance"); Md. Ann. Code, art. 27, § 313A (Supp. 1965 ("any narcotics, drugs, or any other noxious substances or chemicals containing any ketones, aldehydes, organic acetates, ether, chlorinated hydrocarbons, or any other substances containing solvents releasing toxic vapors, as cause conditions of intoxication, inebriation, excitement, stupefication, or dulling of the brain or nervous system. This section applies with particularity to fingernail polish, model airplane glue, or any substance or chemical which has the aforementioned effect upon the brain or nervous system when smelled or inhaled."). Maine Rev. Stat., ch. 17, § 3475 (Supp. 1966) ("any liquid, solid, or mixed substance having the property of releasing toxic vapors"). N.J. Rev. Stat., § 2A: 170–25.9 (Supp. 1965) ("the phrase 'glue containing a solvent having the property of releasing toxic vapors or fumes' shall mean and include any glue, cement, or other adhesive containing one or more of the following chemical compounds: acetone, an acetate, benzene, butyl alcohol, ethyl alcohol, ethylene dichloride, isopropyl alcohol, methyl alcohol, methyl ethyl ketone, pentachlorophenol, petroleum, ether or toluene").

[519] Ill. Rev. Stat., ch. 38, § 81–1 (Supp. 1965) ("* * * breathe, inhale, or drink any compound, liquid, or chemical containing * * * for the purpose of inducing a condition of intoxication, stupefaction, depression, giddiness, paralysis or irrational behavior or in any manner changing, distorting, or disturbing the auditory, visual, or mental processes"); Maine Rev. Stat. Ann., ch. 17, § 3475 (Supp. 1966) ("* * * for the purpose of dulling his senses, intentionally inhale the fumes from any liquid, solid, or mixed substance having the property of releasing toxic vapors"); N.J. Rev. Stat. 2A: 170–25.10 (Supp. 1965) ("* * * for the purpose of causing a condition of intoxication, excitement stupefaction, or the dulling of his brain or nervous system, intentionally smell or inhale the fumes from any glue containing a solvent having the property of releasing toxic vapors or fumes").

[520] N.J. Rev. Stat., § 2A: 170–25.11 (Supp. 1965).

[521] Hawaii Rev. Laws, § 53–5.5 (Supp. 1965).

[522] Md. Ann. Code, art. 27, § 313A (Supp. 1965) ("intoxication, inebriation, excitement, stupefaction, or dulling of the brain or nervous system").

[523] Ill. Rev. Stat., ch. 38, § 81–2 (Supp. 1965).

[524] N.J. Rev. Stat. 2A: 170–25.12 (Supp. 1965).

[525] Md. Ann. Code, art. 27, § 313A (Supp. 1965).

[526] N.J. Rev. Stat. 2A: 164–A (Supp. 1965).

[527] Blum Report at 62.

REPORT ON THE TREATMENT OF DRUG ADDICTION[1]

by Jonathan O. Cole, M.D.

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The following report summarizes the currently available information on the treatment of opiate addicts. It has not been possible in the time available to do a thorough survey of all major and minor treatment programs. However, discussions have been held with a large number of knowledgeable individuals from most major cities. It appears unlikely that extensive brief visits to other treatment facilities would add appreciably to the recommendations made in this report.

As a general impression, it is worth stating that the past 2 or 3 years have seen the rapid emergence of a variety of quite diverse and quite new approaches to the treatment of heroin-dependent individuals. None of these has been fully evaluated. Further, none of these new approaches is necessarily a complete and total treatment program in its own right. This appears to be a remarkably poor point in history to make any firm recommendation that one and only one treatment approach is to receive a "Good Housekeeping seal of approval" either from the National Institute of Mental Health or from the Crime Commission. In fact, the best general position to take at present is that a number of potentially promising approaches exist and need evaluation singly and in combination. Ultimately some may prove totally effective and some further attention must be given to development of other new approaches.

Jonathan O. Cole, M.D.

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One other general point needs to be made. Absolute and permanent abstinence from the use of opiates, though desirable, cannot be the sole criterion of the success of any treatment program. The overall personal, social, and occupational adjustment of the ex-addict must be considered. If an abstinent addict becomes an unemployed skid-row alcoholic, little has been gained. The periodically readdicted individual who has achieved a good work adjustment and a relatively stable family life will pose serious problems to a treatment program in making a judgment as to success or failure. Methadone maintenance, as a treatment, raises the possibility that a chronic, relatively benign addiction should be tolerated, if all other measures of success indicate a net benefit to the patient and to society.

CONTROL AND TREATMENT METHODS

What, then, are the available treatment methods which need to be considered? These need to be crudely grouped into voluntary and involuntary approaches. This poses some problem since voluntary commitment is often only relatively voluntary, being chosen by the addict in lieu of imprisonment or being deserted by his wife or other less desirable consequence.

INVOLUNTARY TREATMENTS

1. *Imprisonment.* Being placed in jail or prison for a short or long period is a frequent result of heroin addiction. Available followup studies (Vaillant) do not suggest that this treatment, per se, has any particular benefit

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[1] This paper was prepared by the staff of the National Institute of Mental Health in response to a request of the Commission for a report on various aspects of the treatment of drug addiction. It was submitted to the Commission in May 1966.

to the individual, although it may be good for society. It is possible that the addition of more intensive treatment and rehabilitation programs to conventional incarceration might be worthwhile, but this has not been demonstrated to be effective and is only being tried in a few locations (Puerto Rico; Walpole, Mass.; Philadelphia, Pa.). Prisoners have been treated at the U.S. Public Health Service hospitals at Lexington and Fort Worth for many years. It may, of course, be that repeated imprisonment is one of the factors leading to the probable aging out whereby older addicts gradually give up their drug use.

2. *Imprisonment Plus Parole.* There is evidence (Diskind) that intensive parole supervision is more effective than minimal parole in keeping addicts drug free and out of criminal activities. There is also a followup study (Vaillant) which suggests that conventional parole, per se, may be useful in keeping addicts off drugs.

Diskind and Klonsky of the New York State division of parole have reported on three followup studies. The longest followup study looked at 673 offenders referred between November 1, 1956 and December 31, 1961. Their adjustment as of December 1962 was noted. Twenty-seven percent made a fully satisfactory recovery (abstinent and without further criminal record) while 36 percent were at least abstinent. The median length of supervision for the successful cases was 16 months (range 2 months to 2 years) compared with 8 months for unsuccessful cases.

The authors point to the fact that unsupervised patients in the community have been shown (in 90 percent of cases) to relapse in 6 months, whereas their group showed only 69 percent relapse in this time period.

Even more conventional parole may have some impact. Vaillant (American Journal of Psychiatry, January 1966, p. 727) reported that long-term (greater than 9 months) imprisonment could lead to a higher rate of short-term abstinence than short-term incarceration. However, supervised release (i.e., parole) was associated with a better long-term adjustment. In Vaillant's sample, 67 percent of long-term imprisonments followed by parole of 1 year resulted in long-term abstinence ($N=30$). Long-term abstinence was herein defined as greater than 1 year.

3. *Probation.* Assuming that the patient's addiction can be medically handled in a hospital, or in jail before trial, there is no a priori reason for believing that probation might not be as effective as parole.

4. *Involuntary Commitment.* The major difference between this modality and those noted above lies in the facilities and personnel being used. Psychiatric hospitals and psychiatrically run aftercare clinics would be employed with imprisonment lurking in the background as a threat to induce compliance.

5. *Voluntary Commitment.* If this is accepted in a setting of threat of trial and imprisonment for noncompliance, the differences for the individual addict may be more apparent than real. However, involuntary commitment usually follows criminal conviction while voluntary commitment may precede any trial or conviction. The individual addict may be less stigmatized by the latter approach. It seems unlikely that these factors per se would have any major impact on treatment outcome, though they may indicate precommitment differences in the kinds of addicts getting into either system.

All of the above methods can be viewed as devices for forcing addicts to expose themselves to surveillance and treatment. If only the formal legal procedures exist without staff or facilities, there may be little difference in outcome between approaches.

VOLUNTARY TREATMENTS

Four major voluntary treatment settings exist:

1. *Medical-psychiatric.* A number of hospitals will admit heroin addicts on a voluntary basis for detoxification with or without other treatment modalities being applied. These may be utilized by addicts under legal pressure to avoid trial and imprisonment and, thus, resemble voluntary commitment but without quite as much pressure for cooperation in long-term treatment. Addicts may seek hospitalization to reduce the size and cost of their habit without any motivation for a real cure. They may also be used by addicts really wanting help. The efficacy of such programs may be quite different for each of the three groups of patients.

2. *Synanon-type Programs.* Several primarily nonmedical programs exist which utilize ex-addict personnel and group pressures and therapeutic community and interpersonal confrontation techniques to help addicts face their problems and change their behavior.

3. *Addicts Anonymous.* This voluntary group program modeled after Alcoholics Anonymous provides group meetings and interpersonal support.

4. *Religious Program.* These rely on religion as a major motivation for abstinence.

ANCILLARY TREATMENTS AIMED PRIMARILY AT ENSURING ABSTINENCE

1. *Nalline Testing.* California and a few other programs utilize periodic injections of Nalline, a narcotic antagonist to test patients for evidence of readdiction. Addicted patients show pupillary dilation; nonaddicted patients show pupillary constriction.

2. *Urine Testing.* Thin-layer chromotography and, potentially, other methods, can be used to examine the urines of addicts under treatment for the presence of opiates.

3. *Cyclazocine.* This long-acting Nalline-like drug, if taken daily in large (4 mg. or larger) doses can, apparently, successfully prevent even relatively large doses of heroin from having any effect. Readdiction is therefore impossible.

4. *Methadone.* This long-acting opiate, if taken daily in a relatively large dose, provides a substitute addiction which also make heroin-taking ineffective.

All four methods are designed to prevent readdiction to heroin. The Nalline and urine methods both discourage readdiction and insure that relapses will be picked up. The rapidity and reliability with which this is done depends on the frequency of testing. Both methods pose a secondary problem. Should occasional brief returns to heroin use result in return to an institution—penal or medical—or should they be used as a focus of discussion in outpatient treatment? If the latter, how much heroin use is too much?

All four methods depend on the patient's daily or periodic compliance, but can be used in either voluntary or involuntary programs. They all provide forms of external control over the addict's behavior.

ANCILLARY TREATMENTS AIMED AT REHABILITATION

1. *Individual Psychotherapy.* Work with an individual addict by a single treater has been frequently attempted. The types of therapists have included psychiatrists, social workers, psychologists, ministers, parole officers, and even ex-addicts. The kinds of treatment used have included everything from psychoanalytically oriented psychotherapy to intensive reality-oriented supportive psychotherapy to less structured irregular contacts. It is often difficult to define this modality and the approach used may vary widely even with different patients seen by the same therapist. A single study (Levine and Ludwig) has demonstrated that LSD, a psychotomimetic drug, given with hypnotherapy, can produce a significant short-term favorable change in the attitudes of addicts toward themselves and toward the future. This approach needs further evaluation with followup of treated addicts into the community. LSD in this context is chiefly a way of intensifying the impact of short-term psychotherapy.

2. *Group Psychotherapy.* Again the level and nature of this treatment of addicts in groups varies greatly and can include everything from formal psychoanalytically oriented group psychotherapy to psychodrama to Synanon and Addicts Anonymous.

3. *Milieu Treatment.* Here structured settings are used as a treatment modality. At the Synanon end this can resemble chronic 24-hour group psychotherapy. At the minimal end it can consist chiefly of a drug-free environment which provides reasonable rules and regulations and some activities to keep patients occupied.

4. *Special Living Arrangements.* Here again Synanon houses, halfway houses or, potentially, placement of addicts to live with normal families can be used to give the addict a stable place to live in the community while attempting to build a better life adjustment for himself back in the community. Patient clubs providing recreation and social contacts during evening and weekend hours can also be included here.

5. *Vocational Rehabilitation.* Since many addicts have never achieved any stable work role, training ex-addicts may be necessary to make them employable or to enable them to hold jobs which will be satisfying and offer hope of a better future. Such training can, of course, take place in institutions or on an outpatient basis. Job placement for addicts who have skills is also a necessary service.

6. *Family and Social Services.* Work with the addict's family may be useful in correcting old and harmful interpersonal attitudes and behaviors and in helping the family support and assist the patient. For patients without families, assistance may be needed to find reasonable places to live and to develop recreational and other leisure-time activities. Ex-addicts may also need help with a variety of medical, social, or legal problems which may not be directly related to their past addiction.

The above lists cover most of the currently possible techniques and approaches to the treatment of heroin addicts. At present, there is little basis for identifying any particular constellation of approaches, facilities, and services as being most effective.

In addition to the above treatment modalities, more extensive community programs generally preventive in scope must be noted. HARYOU-ACT and the Lower East Side Information and Service Center for Narcotics Addiction come under this rubric, having intentions of substantially altering the attitudes of the community in which heroin addiction occurs.

WHAT IS KNOWN ABOUT THE EFFECTIVENESS OF TREATMENT PROGRAMS FOR HEROIN ADDICTS?

In general, the field suffers greatly from a lack of sound and detailed evaluations of treatment efficacy and even more seriously from a lack of systematic attempts to compare different treatment approaches.

We have been able to identify only two such studies which have been completed. Both were done in a parole setting, one under Diskind at the New York State division of parole in New York City and the other by Dr. Konietzko and Mr. Levitt at the Pennsylvania board of parole in Philadelphia. Both give some support to the substantial superiority of intensive, active supportive parole supervision by specially trained parole officers with small case loads. In the Philadelphia study, a mandatory group therapy experience coupled with intensive parole led to the best outcome. There, however, a no-special-treatment control group did almost as well on some crude criteria—parole violations, re-arrest, readdiction, etc.—possibly because they were loosely supervised and less likely to have some types of deviant behavior detected. The results in New York City were more clear.

Generally similar controlled studies are now in progress at the Washington Heights Clinic in the Bronx and at Daytop Lodge, a program operated under the Brooklyn courts. Work at New York Medical College and Metropolitan General Hospital in Manhattan is underway, studying both methadone maintenance and cyclazocine treatments on a pilot basis. This may lead to a controlled comparative study.

A somewhat larger number of studies have attempted followup evaluations of treatment outcome on a naturalistic basis. These studies are hard to compare both because of differences in the specific outcome criteria used and in the types and kinds of addicts admitted to the program initially. Methodological problems in this area will be discussed in more detail below. There is overwhelming consensus, based on a good deal of evidence, on a few statements about the outcome of treatments of heroin addicts.

1. Methadone treatment during the acute withdrawal phase is safe, sound, and reasonable and is superior to the use of nonopiate tranquilizers and sedatives.

2. The relapse rate following simple institutionalization (medical or penal) and release without aftercare or rehabilitation is very high.

3. Three classes of opiate addicts may show a somewhat better prognosis for abstinence independent of treatment:

(*a*) Medical addicts—patients becoming addicted in the course of treatment by physicians for real or functional physical complaints
(*b*) Physicians or other professional addicts
(*c*) Older heroin addicts

4. Enforced parole or aftercare leads to less readdiction or reimprisonment than minimal or no aftercare treatment.

5. Most heroin addicts do not cooperate well in formal interview-type dynamic psychotherapy or casework of the sort ordinarily provided to middle-class psychoneurotics.

6. Most heroin addicts have a large array of needs and inadequacies over and above their use of narcotics—no money, no place to live, no readily marketable job skills, low frustration tolerance, low interest in or experience with the usual activities and pressures of the "square" world, plus, usually, difficult family situations, plus low motivation to solve any of these problems and little trust in professional therapists.

Given the above as a reasonably probable set of facts, it is interesting to note that programs claiming substantial (if often undefined) success may be superficially very different (e.g., Synanon, Daytop Lodge, the California Rehabilitation Center, New York City's intensive parole, methadone, cyclazocine, frequent urine testing) but all have several elements in common:

1. Considerable outside pressure to stay off drugs—provided in Synanon by group pressure and in more penal programs by a real threat of return to an institution.

2. Reasonably frequent supportive contact with the treatment agency.

3. Some assistance or encouragement to get a job and find a suitable place to live.

Given all the above, a number of areas of disagreement exist as to the best treatment approach.

1. *Voluntary vs. Involuntary Treatment.* This is, in part, an ethical philosophic issue relating to one's attitude to force vs. free will. Although voluntary programs like Synanon may, as they claim, do very well (this program refuses to give any data at all on its failure rate or allow controlled evaluation), at the moment it seems unlikely that most addicts will seek voluntary treatment spontaneously. The parallel question concerns the long-term efficacy of various approaches. Do Synanon graduates living in the ordinary world do better than addicts who have stayed off drugs and adjusted reasonably well during a prolonged obligatory parole or aftercare program and are then left without controls? We know of no data pertinent to answer this question.

2. *The Optimal Period of In-Patient Treatment.* Again, although it would appear reasonable that intensive psychotherapy, sociotherapy and vocational rehabilitation in an inpatient or prison setting should enable the addict to do better when he is returned to the community, we know of no positive evidence that this is the case. Although there is some evidence in addicts that some physiological alterations (slightly elevated body temperature, elevated blood sedimentation rate, increased cold-pressor test response) may persist for 5 or 6 months after withdrawal from opiates, the relation of such abnormalities to psychological craving for heroin or to actual return to heroin use is unknown. This latter problem needs systematic study, since hospitalization is expensive and may be unnecessarily prolonged for no valid reason.

3. *Treatment Setting.* Are medical settings really superior to penal ones? Does treating addicts in settings devoted solely to the treatment of addicts help or hurt? It has been claimed that such settings teach naive addicts how to become professional and competent addicts. Are addicts really too troublesome to be treated on ordinary psychiatric or medical services? Are ex-addict personnel necessary or particularly effective? Or is their use partially justified because it creates jobs for ex-addicts?

CURRENT TREATMENT FACILITIES

Federal. At present the U.S. Public Health Service hospitals at Lexington and Fort Worth provide chiefly inpatient treatment for voluntary and prisoner addicts and lack effective aftercare programs. The Fort Worth hospital has recently received mental health project grant support to develop a close pre- and post-hospitalization liaison with medical and social agencies in the San Antonio area. The major advantage of this program is that it provides confidential treatment and, for some communities which lack even minimal voluntary inpatient treatment programs, provides a useful, if distant, resource.

State. The only major State hospital program is currently in New York State where about 800 beds exist in seven State hospitals under the Metcalf-Volker Act. Aftercare facilities exist but are not extensive or adequate. There were approximately 2,000 first admissions with a diagnosis of drug addiction, to all United States, State or county mental hospitals in 1963, one-third of these in New York State. Only California, Georgia, Connecticut, Mississippi, New Jersey, North Carolina, Ohio, and Oklahoma admitted more than 50 such patients in that year. California has a large correctional program, with prolonged inpatient care at the California rehabilitation Center in Corona which serves the whole State and almost 2,000 resident patients. Compulsory aftercare with parole supervision and Nalline and urine testing is carried out in a series of clinics around the State. Other States, Michigan and the District of Columbia, have laws which would permit establishment of a similar program but do not have adequate treatment or aftercare facilities to provide care for committed patients. New Jersey is beginning a State treatment program assisted by a National Institute of Mental Health grant to the New Jersey Neuropsychiatric Institute near Princeton.

Cities. Only New York City appears to have any number and variety of treatment facilities. Chicago has no voluntary treatment program except St. Leonard's House, a religiously sponsored halfway house that also provides limited counseling and social work services. Medical inpatient withdrawal can be obtained only through imprisonment with treatment at Bridewell Hospital, a unit run by the Cook County jail. Detroit and the District of Columbia have inpatient detoxification units which accept voluntary admissions but have very limited aftercare facilities. Philadelphia has a small State- and city-sponsored outpatient facility which also serves alcoholics. Addicts lacking hospitalization insurance are occasionally admitted to Philadelphia General Hospital but only on an individual, negotiated basis. The Board of Parole provides an active pre- and post-released treatment program for prisoner addicts.

In Pittsburgh, a single psychiatrist with a little help, uses beds at a State hospital and does an active job of contacting addicts and arranging assistance for them from a variety of medical and social agencies. Massachusetts has recently created a small inpatient unit at Boston State Hospital with some aftercare facilities.

In Baltimore, heroin addicts can be admitted to Spring Grove State Hospital for withdrawal and a little inpatient treatment. A small grant-supported parole clinic provides parole supervision, group psychotherapy, and frequent urine testing to paroled prisoners.

In New Orleans, detoxification can be obtained on an inpatient basis at Charity Hospital, but no systematic aftercare program exists. Nonopiate drug abusers but not opiate abusers are treated in the local alcoholism treatment program.

A small halfway house for addicts has been established in Houston, Tex. Some outpatient supervision and urine testing is provided at the Houston State Psychiatric Institute.

The only large innovative local treatment programs outside New York, with the exception of the parole program in Philadelphia, is Synanon in Santa Monica and a local clinic in Stamford, Conn., which provides a variety of services for addicts, working actively and effectively with other community agencies.

Even in New York City, where a recent survey listed 25 separate clinics, hospitals, or agencies providing some kind of services to about 15,000 addicts in 1962–63 (possibly an inflated or heavily duplicated count) one gets the impression of a wide variety of somewhat fragmentary treatment programs—a religious group program here, a halfway house there, inpatient facilities with varying outpatient resources, a vocational rehabilitation unit, a day-and-night center, a unit specializing in contacting jailed female addicts, two Synanon-like units, a methadone maintenance program, and some programs promising all things to all people, with almost all lacking good evaluative procedures.

Foreign Programs. There has been a great deal of discussion about the "British system." The best evidence from informed observers, British and American, indicates that the British method of allowing physicians to provide continuing supplies of an opiate to selected addicts who could not function without drugs has worked well with opiate-dependent inviduals who tended to be older, hypochrondriacal, or possessed of chronic medical conditions, and had become dependent on narcotics as a result of medical treatment. The number so treated had never been very large. The total number of addicts in the British Isles was for many years below 500. Britain has recently seen the emergence of young, sociopathic addicts and a reported increase in number of almost 100 percent, and it appears that free sustaining of narcotic habits in these patients is less satisfactory. Also, some physicians may now be functioning as "script" doctors. An interdepartmental committee under the chairmanship of Lord Brain in 1965 made a series of recommendations which, if implemented, would set up U.S.-type controls in Britain and would restrict the prescribing of heroin or cocaine for addicts to certain special treatment centers.

Israel has been moving in the same general direction. Earlier free opiate drugs were made available to all patients who claimed to be addicts. This system was used by some nonaddicts to obtain opiates for resale on the black market. Now all presumed addicts are hospitalized to determine if physical dependence exists.

In Canada, programs vary from Province to Province. Both British Columbia and Ontario have been utilizing maintenance methadone treatment with some reported success. In Vancouver, this drug is given to older addicts for a few months to ease the transition to abstinence. A committee of the Canadian Medical Association, in a statement published in the CMA Journal (vol. 92, p. 1040, 1965), concluded that methadone could be used for gradual withdrawal or prolonged maintenance and recommended a series of safeguards to be followed by any physician attempting maintenance therapy to insure that he was the only source of methadone for each patient. Their law, as ours, is bound to good medical practice, the exact wording is that doctors must be able to present credible evidence that the narcotic is "required for the condition for which the patient is receiving treatment."

In passing, it should be stated that if the American Medical Association were to make a similar statement, our law, in the informal opinion of Mr. Donald Miller, Chief Counsel of the Bureau of Narcotics, would then permit prolonged methadone maintenance treatment.

The program at the Alcoholism and Drug Addiction Research Foundation in Ontario has several interesting features:

1. Methadone buffered withdrawal from opiates is carried out on an outpatient basis.
2. No direct psychotherapy is attempted early in treatment.
3. Patients adjusting poorly after abstinence has been achieved are tried on maintenance methadone (at about 30 mgs. per day). About half the 46 male addicts begun on this program are doing satisfactorily. Female addicts have responded less well.

DESCRIPTIONS OF A REPRESENTATIVE SPECTRUM OF TREATMENT PROGRAMS IN THE UNITED STATES

Daytop Lodge. An open, voluntary treatment program serving drug addicts placed on probation by the local courts in Brooklyn, N.Y. This is, technically, a halfway house but has a much more active treatment program headed by a Synanon-trained ex-addict and staffed chiefly by ex-addicts. The major features are:

1. The newly referred addict is made to fight his way into the program.
2. Rigid high standards for behavior in all areas are expected and enforced by all patients.
3. The new addict is treated as a helpless child at first but gradually moves from menial to responsible jobs at the lodge and finally to work outside.
4. Vigorous, aggressive, "gut-level" group sessions are held frequently.
5. More intellectual, philosophic seminar sessions are also held.

The similarity to Synanon descriptions is striking, the major differences being that Synanon is a purely voluntary private organization, while Daytop Lodge (capacity 25) is supported by a National Institute of Mental Health grant and is under court sponsorship. Very recently, the Daytop Lodge program has been moved to a larger 130-bed facility which receives support from the city of New York and now also accepts voluntary admissions and patients from sources other than the Brooklyn courts.

Puerto Rico. Dr. Ramirez, now in charge of the New York City narcotics addict program, has developed an elaborately phased program in which addicts first get involved either while still addicted or in prison, attend group sessions, and gradually work their way through phases of increasing responsibility and increasing involvement in the contacting and treating of other addicts. As of February 1966, it appeared that the few full graduates of this program were all employed by the program as helpers for new patients.

California Rehabilitation Center, Corona, Calif. This treatment program, under the corrections system of the State, has been running for 4 years. All patients, even volunteers, are committed, volunteers for 2½years, while patients committed following a criminal conviction have a 7-year commitment.

The inpatient treatment program is modeled on Maxwell Jones' "therapeutic community" concept, with 60-man living groups comprising the treatment unit. Daily group discussion meetings are held at which both current living problems and deeper matters are discussed. Emphasis is also given to increasing assumption of responsibility by the patients. Work therapy, school, and vocational training are provided. The period in the institution is relatively long, at least 6 months being required by law. Actual inpatient time is averaging 15 months for men and 11 months for women. The timing of release to the community is based on staff evaluation of each patient's evidence of growth and strength and ability to assume responsibility for his own behavior.

On return to the community, patients are intensively supervised by caseworkers with special training and low (30) caseloads, including weekly group meetings and individual contacts with each patient, at home or on the job. Nalline tests are given, both on a regular and surprise basis five times a month for at least the first 6 months.

Urinalysis is now being studied as an alternative monitoring technique. Patients showing signs of relapse—either a return to drugs or heavy drinking or inability to hold jobs or other delinquent activity—are returned to Corona for further treatment. A halfway house program is being developed.

In December 1965, there were 1,672 males and 268 females in the center. Also 2,578 men and 665 women had been released to the community. Almost half had been returned to the center for further treatment. Only about 33 percent of released patients last a year in the community free of drugs, but only half of those returned for further treatment had actually returned to heroin abuse.

Parole Supervision. As noted above, programs both in New York and Philadelphia utilize specially supervised and trained parole officers with small caseloads in the treatment of addicts released from prison, usually with contact between the addict and the parole officer prior to release. The parole officer actively works with the addict in a mixture of supervision, supportive psychotherapy, and active environmental manipulation. Contact is maintained with the addict's family and employer and other community agencies are enlisted to assist the addict to develop an effective social, family, and work adjustment.

Fort Worth and Lexington U.S.P.H.S. Hospitals. These programs include detoxification, a stable controlled environment, some access to individual and group psychotherapy, educational and vocational rehabilitation programs, industrial and recreational therapy. The results of this program in either voluntary addict admissions who are supposed to stay 5 months, but average about 6 weeks, or for prisoner patients, are relatively poor. About 10 percent stay drug-free for the first year after release.

Several followup studies of Lexington patients point to the need for adequate care in the community (following discharge). The 12-year followup of 100 narcotic addict in New York admitted to Lexington between August 1952 and January 1953, by Vaillant, has been mentioned previously. Hunt and Odoroff studied 1,912 patients referred by the Lexington Hospital to the New York Demonstration Center of NIMH from July 17, 1952, to December 31, 1955. Of these patients, 87.3 percent were classified as readdicted within 12 months of discharge. Duvall, Locke, and Brill (Public Health Reports, March 1963, vol. 78, No. 3, p. 185) took a stratified sample of 453 persons in this group and followed them for a period of 5 years. There were 52 deaths in the sample (19 under age 30 and 33 over age 30). Furthermore, 15 out of 19 deaths under age 30 were directly attributable to narcotic usage. The authors estimated that 91 percent of their total sample had relapsed 6 months after discharge from Lexington. However, at 2 years, the abstinent rate had jumped from 9 percent (at 6 months) to 17 percent; and by the fifth year, the voluntary abstinent rate had again jumped to 25 percent. These data supported the "maturing out" hypothesis of Winick (U.N. Bulletin on Narcotics 16: 1, 1-11 (1964)). Hunt and Odoroff also supported this hypothesis. In addition, these authors also found better abstinence rates in: (*a*) Involuntary patients aged 30 or more as compared with their voluntary counterparts, (*b*) the white nonvoluntary groups less than 30 years of age as compared with their Negro counterparts, and (*c*) patients under 30 staying in hospital 31 days or more as compared with those staying 30 days or less. No improvement in readdiction rates was demonstrated for prolonged hospitalization in excess of 30 days.

O'Donnell (American Journal of Orthopsychiatry, vol. XXXIV, No. 5, October 1964, p. 946) reported on Kentucky residents who were treated at Lexington between May 1935 and December 1959. His sample size was 266, more than half of whom had died by the end of the followup period in October 1963. More than half of the living subjects were abstinent when located.

In essence, these figures provide a sample of rural-based patients (where narcotics are not readily available) and contrast with the data offered by Vaillant, Hunt and Odoroff, and Duvall, et al. (above).

John C. Ball and Emily Cottrell (Public Health Reports, vol. 80, No. 6, p. 471, June 1965) examined the admission of addicts admitted to Lexington and Fort Worth from 1935 to 1963. During this period there have been 40,513 first admissions of male patients to both hospitals and 8,471 female first admissions. The annual admission rate has varied, with the peak having been reached in 1950. In 1937, Southern States provided the bulk of admissions to Lexington, whereas New York (and especially New York City) offered the most admissions in 1963. In addition, addict patients were younger, were more frequently heroin users, and were more likely Negro or Puerto Rican in 1963 (as compared with the late 1930's).

Methadone Maintenance Treatment. This approach has been recommended by Drs. Dole and Nyswander but has also been used by Dr. Jaffe at Einstein and by Canadian groups. It consists of two variants:

1. Gradual outpatient withdrawal with methadone being administered in slowly decreasing doses for several months but leading reasonably directly to total abstinence.
2. Prolonged maintenance on relatively high dosages of methadone (up to 80–100 mgs. per day) in a single supervised daily dose of liquid medication. At this level, self-administration of relatively large amounts of illicit heroin has little effect. The patient is thus "protected" against illicit heroin abuse.

As managed by Dole and Nyswander, their program has a certain missionary zeal and esprit de corps which may be partially responsible for their claims of almost universal success. Of 108 patients started in their program prior to February 1, 1966, 101 were still under their care. Of the 48 patients under treatment for 8 to 25 months, more than half were employed or in school and were self-supporting.

This program is currently being extended to a new parallel unit at Harlem Hospital.

It should be noted that the methadone is accompanied by a good deal of supportive contact and pressure toward rehabilitation. It will be interesting to see whether other units not run by this dynamic duo will have similar success. Urinary monitoring for abuse of heroin or other drugs is employed. Dr. Dole does not deny that his patients may abuse some nonopiate drugs, but claims that they take no drugs which they had not taken prior to treatment.

Freedman, at Metropolitan Hospital, in New York City, has also begun about 20 patients on methadone, but finds the drug less free of side effects and less enthusiastically received by his addict patients than has Dole. Less than half his patients can be considered successes.

Jaffe, in a much smaller group of addicts with repeated failures on other programs, has found that maintenance opiate administration plus urinary monitoring and firm pressure on the patient to get a job and lead a socially responsible life can be quite useful. The threat of withdrawal of drug supplies gives the therapist a powerful lever with which to move the patient toward a more normal social adjustment.

Cyclazocine Treatment. This long-acting opiate antagonist (similar to Nalline) developed as a drug by Winthrop Pharmaceuticals and developed as a potential treatment of drug addiction by the National Institute of Mental Health's Addiction Research Center at Lexington, has now been tried as a treatment in addicts on a pilot basis by Jaffe and by Freedman in New York.

If an addict is gradually built up to a daily dose of 4 to 6 mgs. of cyclazocine a day (too rapid increase causes feelings of unreality and hallucinations), the effects of illicit heroin will be essentially completely blocked as long as he keeps taking the drug. In the pilot studies noted above, this treatment has been well reecived by the first 20 addicts begun on it, with only one failure. The drug is well-tolerated as a treatment procedure in addicts. The treatment is monitored by frequent urinalysis.

Philadelphia Board of Parole. Here prisoners with a history of addiction are begun on group therapy sessions in prison several months before release. They continue with the same therapist after release and receive relatively intensive parole supervision and casework from specially trained parole officers with small caseloads. Some urine testing is done. A 60-percent success rate for the first year after release is reported.

Baltimore Drug Addiction Clinic. Here, addicts are contacted in prison concerning interest in a daily urine testing program. If they volunteer for the program and can obtain a job, they are followed daily in a clinic in downtown Baltimore with active parole supervision and some group psychotherapy. Positive urine tests are initially used as a basis for intensive discussion of the patient's dynamics and problems. Continued drug taking leads to return to prison. About a 30-percent abstinence rate for the first year appears to be achieved.

TREATMENT FOR PERSONS USING NON-OPIATE DRUGS OF ABUSE

There are no special treatment facilities specifically designed to serve individuals dependent on nonopiate drugs and most programs are restricted to opiate addicts.

Withdrawal detoxification of patients heavily dependent on barbiturates or most other sedatives and some tranquilizers (e.g., meprobamate or chlordiazepoxide), can pose serious difficulties requiring more intensive medical supervision than does opiate withdrawal. If dependence is undetected and convulsions and delirium occur, administration of barbiturates can sometimes fail to reverse the process. Deaths can occur.

Although adequate data are lacking, abusers of barbituates and amphetamines probably include more medical (doctor-dependent) abusers and fewer street users than is true for opiate abusers. It seems likely that some combination of intensive supervision and treatment plus regular urine monitoring to detect relapse might be useful, but more study of this group or groups of drug abusers is needed urgently as a basis for clearer recommendations.

Abusers of LSD or other hallucinogens who develop psychiatric symptoms (schizophrenic-like or panic reactions) can probably be adequately handled in conventional psychiatric settings.

POSSIBLE NEW METHODS OF TREATMENT

1. A cyclazocine-like drug with a much longer duration of action (3 days to 2 weeks) would be useful since the patients would have to come to the clinic less frequently.
2. Formal conditioning theory, as extended by Wikler and Martin, suggests that cyclazocine or similar treatments could be made more effective if the addict tried heroin or a similar drug several times and got no effect, thus extinguishing his earlier conditioned positive response to the drug.
3. Behavior therapy—a form of conditioning treatment developed chiefly by Wolpe in this country has been applied successfully to one physician addict. This work could be extended.
4. Preliminary reports from Iran claim that an anti-depressant phenothiazine combination (amitriptyline-perphenazine) is effective in Persian addicts in preventing relapse.
5. Obviously addicts are a heterogeneous group of people and if further research could tell us which patients do better on which kind of treatment, a substantial advance would have been made.
6. As with alcoholism, it is likely that addicts might benefit from better integration and coordination of the various medical, social rehabilitation, and welfare services available in most large cities.
7. It is possible that the treatment of heroin addicts in nonaddict settings—general hospitals, psychiatric clinics, a doctor's private office—might aid his separation from the addict culture. This possibility should be explored.

ROLE OF STATE, LOCAL, PUBLIC, AND PRIVATE GROUPS

It is difficult to comment on the question, "Who should do what in the treatment of drug addicts?" At present in most places the answer is that more agencies should do more, and that at least one agency should provide a solid, comprehensive program, alone or in collaboration with other agencies. Detoxification facilities should be available without the addicts having to be committed or convicted. It is probable that both voluntary and involuntary programs should be available, the latter being used for failures of the former. At the present state of our knowledge the availability of several different treatment programs seems preferable to a simple rigidly fixed program.

A picture, projected into the future, of a comprehensive program for a city with a substantial drug abuse problem (500 new cases per year) based on current knowledge might include the following components and interrelationships:

1. A major central treatment facility integrated into a medical school and a community mental health center providing inpatient detoxification for about half the city's voluntary and committed patients plus longer term inpatient intensive treatment for selected treatment-resistant patients from all over the city. The inpatient unit would also start appropriate patients on cyclazocine and methadone treatments and would carry out careful pre-release planning for aftercare, utilizing staff of the aftercare portion of the facility.

The aftercare program would encompass day and night care, halfway house, a vocational rehabilitation and sheltered workshop facilities, a variety of levels of psychotherapy, casework and utilization of other community agencies—public and private.

This unit would provide training not only for young professionals from the university but for treatment staffs from other community mental health centers, hospitals, police forces, prisons, and public and private social agencies in the area.

It would serve as the agency maintaining a local registry of drug abusers and would maintain liaison with the national registry and would assist the schools and community on educational programs.

2. Other community mental health centers and hospitals would be open to drug abusers and would provide basic inpatient and outpatient treatment programs, utilizing the local drug abuse center for consultation on special problem cases.

3. Jail, prison, and probation and parole programs would be able to handle detoxification and to provide active treatment for drug abusers.

4. Public and private agencies would be open to and secure in handling drug abusers, working with the center on problem cases.

5. A rapid urine testing facility would be available for use in both the diagnosis and treatment monitoring of drug abusers.

EVALUATION OF SUCCESS OF TREATMENT PROGRAMS

This problem has two parts:

1. Better descriptions of addicts entering the program on a multidimensional basis—social background, adjustment, personality, family or social setting, assets and liabilities, addiction, and criminal history, etc.

2. Full description of adjustment during and after treatment, using both cross sectional and longitudinal dimensions. Drug use is one criterion, but even here, a brief return to full addiction or periodic weekend use is not the same as full-time addiction for years. An addiction paid for out of one's salary should be differentiated from that supported by stealing or prostitution. Involvement in addict groups, job and social adjustment, leisure time and recreational activities, efforts at self-advancement all need to be taken into account. Such measures should be considered in context, by comparison with an appropriate nonaddict control group. For example, support by welfare payments may be normal for Negro women of low education with several children and no husband, in Harlem. Some job instability may be normal for lower class high school dropouts.

Most of these phenomena are susceptible to relatively good quantification, but appropriate measuring techniques need to be developed and applied. Comparative studies of treatment efficacy need to be developed. Some effort must also be made to separate the results obtained with a given treatment by a very unique and dynamic person from the results obtained under more usual conditions. Treatment cost is also a relevant concern.

RESEARCH

Current research in the area of drug abuse is showing increasing evidence of sophistication and clinical relevance as well as a healthy growth rate. Major areas of emphasis include the following:

1. Application of new techniques to the elucidation of cellular changes associated with drug tolerance and with the obstinence syndrome.

2. The development of techniques—indwelling venous catheters—which permit monkeys to press a lever to inject themselves with drugs of abuse. Monkeys have already been shown to seek injections of most drugs known to be abused by man. This model can now be used to evaluate new drugs and to study factors influencing drug-seeking behavior.

3. Conditioning methods in the rat have permitted study of the effects of environmental factors associated with earlier addiction on drug-seeking behavior.

4. Better methods for studying effects of drugs of abuse on mood and psychological functioning in man are rapidly becoming available.

5. The development of a number of new treatment approaches to narcotic addicts has increased interest in clinical research in this area.

In general, the most obvious current research needs in this area, over and above further exploration of recently opened areas described above, include the development of better methods for measuring various aspects of adjustment in drug addicts followed in the community and more research looking for predictors of successful clinical response to treatment in general and to specific treatment approaches. For example, patients doing well in Synanon-type programs could be quite different from those benefitting from maintenance methadone treatment.

Well-designed controlled studies of methadone treatment, cyclazocine treatment, urine monitoring, voluntary vs. involuntary treatment are needed, as is a comparison of the Synanon-type approach with other treatment programs. Better evaluative instruments are needed. Such studies will be stimulated in the coming year to complement and extend work already underway.

Studies to explore the possibility of prolonged physiological abnormality after withdrawal are needed to clarify the possibility that bodily changes persist in addicts which may predispose them to readdiction. Such studies might well be combined with a comparative study of the effects of long, intensive vs. minimal brief inpatient treatment, given comparable aftercare treatment programs.

Detailed study of abusers of nonopiates at all levels—sociological, psychological, psychiatric, physiological and biochemical—are badly needed as are studies of treatment response in this area.

A national registry of drug abusers has frequently been recommended and could provide very useful data on the incidence, prevalence and natural course of various types of drug abuse. Legal safeguards to insure the medical confidentiality of such a system would be necessary to obtain adequate reporting from medical and social agencies.

At the pharmacological level, long-acting or depot forms of methadone and cyclazocine or related drugs would be useful, since medication could then be administered at, perhaps, 2-week rather than 24-hour, intervals. A search for a useful long-acting antagonist for barbiturates and related sedative drugs could be attempted also.

TRAINING

The training of professionals and subprofessionals in mental health and related professions in the treatment of narcotic and other drug abusers must be divided into two parts:

1. Training as a component of generic training programs.
2. Special training for work in drug abuse treatment programs.

In neither area are training programs well developed.

In a recent mail survey, carried out by the Institute for Drug Addiction, of 500 universities in the United States and Canada the majority of the responding medical schools provided course material on drugs of abuse only in the pharmacology courses given during the second preclinical year. Formal instruction on the clinical management of drug abusers was not provided. The inclusion of formal material on drug abuse in psychology, social work, and nursing programs was the exception, not the rule. Public health nursing programs were, however, noteworthy for their inclusion of material on drug addiction.

One of the problems here appears to be lack of knowledge of available teaching texts and other materials. The general lack of interest in or knowledge about this special problem may also contribute. Undoubtedly the pressure of other subject matter requiring coverage contributes as does some feeling, partially correct, that general professional training will prepare a student to learn rapidly how to cope with unusual problem areas once exposed to them.

For general medical student and nurses training, material on the pharmacology of the various types of drugs of abuse, the medical handling of withdrawal syndromes and of the social factors and behavioral patterns relevant to drug abuse can certainly be taught. With increasing involvement of nurses in community and public health activities, nurses in training deserve some information on community and aftercare treatment possibilities and the way in which these pose different problems from more conventional psychiatric conditions.

In psychiatric residency, social work, vocational rehabilitation, clinical psychology, and psychiatric and public health nursing, the areas noted above plus more detail on the several possible treatment approaches, the importance of active positive measures and of interagency cooperation, drug treatments and ways of monitoring patients for possible relapse should be added and, ideally, drug abuse treatment facilities, where these exist, should be utilized for supervised clinical experience.

Special intensive training experiences lasting 2 weeks to a month might be developed where both didactic material and opportunity to observe and participate in treatment programs were provided, modelled on a similar program in mental retardation now going on at Letchworth Village, N.Y.

Two special groups deserve mention. Parole and probation officers have been shown to function effectively with small addict caseloads after some special training and supervision. Here inservice training after employment might be appropriate, although some personnel working in these capacities have had, or go on to obtain, social work training.

The other group, ex-addicts, often successful products of existing treatment programs, are currently being utilized in some programs to work with new addict patients. To date most of these have come out of Synanon or related programs and are used in group treatment approaches following that model, although other recovered addicts also have been used in other treatment programs. Given the multiple needs of addicts and their initial reluctance to take personal initiative in seeking services, ex-addicts or other personnel from the addicts' social setting may well be useful. This approach also provides employment for some ex-addicts.

Special training programs for profesional personnel involving full-time experience in treatment programs for addicts—over and above parole personnel or ex-addicts—are also needed. In the past, experience at the U.S. Public Health Service Hospitals at Lexington or Fort Worth has provided a modest cadre of psychiatrists and other profesionals familiar with addicts and with detoxification procedures. Unfortunately, the isolation of these units from community-based aftercare programs makes the training currently available there less than ideal. At the moment, except for young psychiatrists and occasional other professionals assigned to these hospitals while serving 2 years of commissioned-officer duty in the USPHS as an equivalent to military service, and psychiatric residents in the training program at the University of Kentucky Medical School, little formal training is being accomplished at these facilities.

The only training program specifically focused on community aspects of treatment of drug abusers currently fully operative is at the New York Medical College.

There are, therefore, clear needs for expansion of training in clinical aspects of drug abuse. Some immediate expansion in this area is possible. Major expansion will have to await the training of more expert professionals in this field and the development of more centers of research and service excellence. To some extent this can go along with expansion in clinical service, demonstration and research programs and is inextricably entwined with them. Such programs require a core of experienced people but have to add personnel with general professional training without special experience in the area of drug abuse who become trained in the course of the project. Such on-the-job training will gradually be supplemented by more formal training programs, drawing again for teaching staff on personnel developed in the above operating programs. A problem here is that many existing treatment programs are strongly committed to a single treatment approach and may have difficulty providing broader training.

There is an ancillary need for ready access to text materials in this area. Some combination of a compilation of the best published articles in this area and some new material focused especially on the training needs of various subprofessional and professional training programs would be useful and might encourage existing training programs to increase content coverage in the area of drug abuse.

A detailed guide to other existing teaching aids—films, pamphlets, etc.—would also be helpful in some programs, particularly those lacking regular access to appropriate patients.

REGULATORY ACTIVITIES

Although I cannot comment from direct knowledge concerning any specific activities of the Bureau of Narcotics which directly interfere with research or treatment, there has accumulated over the years a general impression in the clinical and research community that undue involvement with opiate addicts on the part of physicians will lead to critical visits from agents of the Bureau and that giving drugs to addicts, even for well-conceived medical purposes, may be illegal and lead to prosecution. This general aura tends to discourage competent people from entering this area of treatment and research. A vigorous statement of this problem was made by the Committee on Public Health of the New York Academy of Medicine in 1963.

Recent statements by the Joint American Medical Association Committee on Alcoholism and Drug Addiction and NAS–NRC Committee on Problems of Drug Dependence should have served to clarify some matters, but may be "too little, too late." Since the Bureau accepts official statements by the AMA as to what constitutes "medical treatment of drug addicts" (legal) as against "sustaining addiction" (illegal), it is now quite legal to provide an addict with methadone to sustain him until he can be hospitalized for detoxification and the range of settings in which methadone detoxification can be done under an experienced physician is being expanded. However, the use of maintenance methadone as a general procedure for sustaining addicts in the community as part of a treatment and rehabilitation program still falls outside the AMA's, and therefore the Bureau's definition of medical treatment.

Research projects evaluating such a treatment regimen are going forward, however. There have been allegations of interference and harassment of addict patients and staff in such programs by Bureau personnel and counterallegations of improper practices by investigators. Both sets of charges are difficult to evaluate and may reflect more an atmosphere of mutual distrust than a serious prevention of research. In fairness, at least one investigator utilizing maintenance opiate treatment appears to have excellent relations with Bureau personnel. It is my impression that gradual changes in the AMA position on acceptable treatment precedures, plus the accumulation of clinical research data, should lead to a gradual, if wary, relaxation in the Bureau's attitudes and an increasingly favorable emotional milieu for research in addiction. If the NIMH's Center for Narcotics and Drug Abuse proceeds effectively in expanding high-quality research in evaluation of methadone maintenance treatment and this approach can be shown to be useful in some types of drug addicts, the current problem may be resolved.

Even the present Bureau position is less restrictive than many physicians realize. Here consultation and training functions by NIMH Center staff may be useful in dispelling unnecessary apprehension in treating physicians.

Most State laws and regulations parallel the Federal ones, though often with less severe penalties. Here a major problem may be the enforcement activities of local law enforcement personnel who may harass addicts attending bona fide treatment programs. One hears stories of addicts being searched on their way into meetings of Addicts Anonymous or into treatment clinics. This may be a matter more for education and consultation at the local level and for involvement of upper level public officials in planning of programs. Some harassment of this sort may be unavoidable until addiction can be established more firmly as a treatable mental health problem and ceases to be a juicy political football.

A review of available State laws concerning the use of opiates in the treatment of drug addicts collected in the Bureau of Narcotics reveals that the majority of the laws closely parallel the Federal law. California is a major exception since it prevents the administration of opiates to addicts outside of an institution and would therefore bar both preadmission maintenance treatment and postrelease maintenance treatment. None of the State laws, with one exception, concern themselves with research at all. It is therefore difficult to tell whether the California law or other State laws would or would not prevent a controlled study of maintenance methadone in the community, for example.

The new New York State law is a model law in many respects. It is the only State law to specifically provide for research on maintenance opiate administration. This form of treatment is specifically permitted under the New York State law.

Two States—New York and Massachusetts—make drug abuse a compulsory reportable illness. Data provided by physicians on the report forms are clearly available to law enforcement personnel in the State. This in itself may well pose a handicap both to the medical treatment of addicts and to the establishment of a medically confidential national register of drug abusers.

COORDINATION OF FEDERAL EFFORTS

In the area of nonopiate drug abuse, good communication and coordination between the NIMH and the FDA's Bureau of Drug Abuse Control is already well established. Dr. James Fox, Assistant Chief of the NIMH's Center for

Narcotics and Drug Abuse, is currently also serving as Chief of the Division of Research and Statistics in the FDA's Bureau of Drug Abuse Control and is recruiting staff and developing the FDA's program in this area. Excellent coordination of the efforts of the two agencies appears well established. The development of comparable relations with the Bureau of Narcotics by both NIMH and FDA is also showing healthy beginnings. Mr. David Acheson's current responsibilities and active supportive interest in such a development will be very helpful. The Bureau has already agreed in an interagency meeting, to assist the NIMH in developing a national register of drug abusers by providing names and other data from its files while expecting only summary data, not names of addicts reported by other agencies, in return. All three agencies have been actively collaborating in planning a program to educate and inform college administrators in the area of drug abuse, with the FDA being the agency directly supporting the program through the contract mechanism.

FEDERAL ACTIVITIES IN THE FIELD OF NARCOTIC ADDICTION

In addition to the development and support of expanded programs of clinical and basic research, demonstration and training activities under the NIMH's Center for Narcotics and Drug Abuse, the center will also be providing consultation of States and localities on the development of service treatment programs. In general, the NIMH position strongly favors the integration of drug addiction treatment programs into community mental health centers. Support for both construction and staffing for such developments is available through the NIMH grant programs in this area. Formula grant funds available to the States through their mental health authorities can also be used for this purpose and if H.R. 3008, "partnership for health," becomes law additional funds will be available to the States for such use and for projects requesting support for the development of new service programs in the area of drug addict treatment. If the administration bill for the Federal commitment of narcotic addicts accused or convicted of Federal crimes becomes law, Federal support of the treatment of such patients in local facilities will also become possible. It is also likely that the Public Health Service hospitals at Lexington and Fort Worth may be gradually increasing their activities in research and training in the area of drug abuse.

However, as a matter of general principal, primary support for service treatment programs for drug addicts belongs with the States and localities. The NIMH and the larger PHS role in this area should emphasize research, training, demonstration, and consultation.

NATIONAL REGISTER OF DRUG ABUSERS

Establishment of such a comprehensive register has been frequently recommended by various committees and advisory groups concerned with the area of drug abuse. In general, such a register should receive information in a simple, standardized format sufficient to identify uniquely each reported drug abuser, to provide some information on his social situation and to provide information on the drugs believed to be abused and the duration and frequency of such abuse.

Reports on drug abusers, including those with physical and psychic dependence, with psychic dependence only, intermittent users, and individuals picked up for illicit possession of drugs of abuse should be submitted by a wide range of medical, police, correctional, and social agencies. All types of drug and substance abuse for psychological effect, excluding alcohol and tobacco and excluding prescribed drugs except where physical dependence had resulted through overuse, should be reported with the reporting agency's judgment being accepted at least initially. Obviously such a system would only provide data on drug abusers whose drug abuse lead to behavior—antisocial, disturbed psychiatric, or socially ineffective—which brought them to the attention of an agency.

The availability of such data on a national basis, over a period of years, would provide unique and valuable data on the incidence, prevalence, and epidemiology of various types of drug abuse and would identify the magnitudes of various aspects of the problem. Such data would have major implications for both treatment and enforcement programs. In addition this data would enable studies to be made of the course of the various types of drug abuse in terms of the likelihood and frequency of contacts with such individuals by various agencies. The kinds of abusers being treated or arrested in different areas or facilities could be readily compared and rough measures of the effectiveness of treatment programs could be obtained. If the social security system could be induced to provide data for groups of various types of individuals in the register, highly relevant data on the positive social adjustment of these patients over time could be obtained.

Obviously register data could not provide detailed or special information on cohorts of patients but could easily identify areas where detailed special cohort studies were indicated. Equally, patterns of drug abuse including individuals not identified by any agency would require study by other survey approaches.

The major problems in developing a reasonably complete and effective register are both organizational and legal.

To obtain adequate reporting of cases from medical and social agencies and from individual physicians, absolute assurance that data on patients would be kept confidential is required. This in turn will require legislation assuring an NIMH-run register such confidentiality.

It is probable that cooperation and reporting of minimal data by police and prisons will be relatively easy to obtain, although requiring data not usually collected may pose problems. A great deal more work will be required to obtain full reporting from other sources. Special staff in various regions will be required to develop and monitor reporting and in some situations agencies may require extra funds to support extra staff and clerical time required in making full and accurate reports. Also a competent and professional central staff and computer and data processing facilities will be needed to run the register and to utilize the data for research and public health purposes. Some pilot programs of the sort envisioned are currently being supported in NIMH, in Maryland and in New York City, and an excellent register of addicts admitted to Fort Worth and Lexington Hospitals has already been established. Data from major State and local treatment programs serving drug abusers (California, New York State, New York City hospitals, Boston, Stamford, Conn.) could be readily obtained at an early phase, as could data from the Bureau of Narcotics and the FDA. The development of a full and complete national registry would have to proceed in steps and might take a year or two before it became fully operational and a longer period before its optimal use for longitudinal studies would be achievable.

OTHER IMPORTANT DEVELOPMENTS

The major recent development in State treatment programs is the establishment in New York of a new commitment program and a State Commission in the area of drug addiction. The Commission is responsible for planning comprehensive inpatient and outpatient treatment programs for opiate addicts committed to treatment under the new law which will go into effect April 1, 1967. It is anticipated that 5,000 addicts a year will be committed for a compulsory 3-year treatment period. It is likely that the State may end up supporting treatment programs in a variety of public and private institutions and agencies. This may well result in an upgrading of treatment programs in New York State since a substantial level of funding is anticipated.

The California Rehabilitation Center at Corona has recently recruited a competent research psychiatrist as director of their research program. This is a particularly valuable step because the California program is already functioning well at the clinical and administrative levels and should be able to be effectively utilized for clinical research activities.

RECOMMENDATIONS

1. At the Federal level, existing mechanisms for the support of research, demonstration, training, and consultation appear generally adequate. With increases in staff at the NIMH's newly formed Center for Narcotics and Drug Addiction, more effective development of needed programs can be accomplished. Available funds are probably adequate for the present fiscal year ($4 million will be available, with at least $1 million of this to be used in funding new programs). However, substantial increases to a level of $10 to $15 million a year over the next few years and a substantial increase in staff positions will be necessary to take advantage of currently apparent needs in these areas. Unfortunately, more staff work is needed before substantially larger sums can be effectively utilized—the mere appropriation of more dollars cannot solve problems.

2. States and cities currently lacking adequate treatment programs for drug addicts must be encouraged and assisted through consultation to develop such programs. Generally voluntary, involuntary commitment, and penal probation-parole programs are all required. Although detoxification facilities and aftercare clinics are a minimal requirement, the integration of such programs into community mental health centers, with utilization of day care, halfway house and vocational rehabilitation facilities and with effective two-way relationships between special addict programs and a wide variety of other social and medical agencies, including police courts and welfare, are equally necessary for an effective treatment program. Such relationships also facilitate early case finding and early treatment and serve to train personnel of other agencies in the treatment of narcotic addicts.

Although individual voluntary or public agencies often develop a highly specialized single treatment approach to drug addicts, every effort should be made to provide a spectrum of treatment programs for addicts with different social and personality problems and at different stages of advancement toward full rehabilitation.

3. Universities must be encouraged to give more attention to training and research in the field of drug abuse. One important approach to this end is the development and support of programs in a few centers of a high order of excellence which can be used as models and can provide consultation and training to key professionals from other universities interested in strengthening their local programs. Better texts, audiovisual materials, course curricula, etc., should also be made available to assist in such developments.

4. In the research area, several problems have immediate high priority:

(*a*) Establishment of a national registry of drug abusers (opiate and nonopiate) protected by legal assurance of medical confidentiality, with a major research mission.

(*b*) Development of basic widely applicable methods for characterizing drug abusers admitted to major treatment programs (medical, social or correctional) and for evaluating adjustment after appropriate time periods.

(*c*) Development of a substantially expanded program of clinical studies evaluating different existing treatment approaches in a systematic manner.

(*d*) Creation of novel treatment methods—psychotherapeutic, social or pharmacologic, with a long-acting cyclazocine having a high priority.

(*e*) Studies at all levels, from surveys to treatment to psychobiology of nonopiate drug abusers.

(*f*) Sustantial expansion of more basic research on all aspects of drug dependence.

CIVIL COMMITMENT OF NARCOTIC ADDICTS AND SENTENCING FOR NARCOTIC DRUG OFFENSES*

by Dennis S. Aronowitz

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The past 20 years have witnessed intense public interest in the problems of narcotics addiction in the United States. Debate has raged continuously over such basic questions as: The dimension and seriousness of the problem; the causes of addiction; the appropriateness of a strict prohibitory policy. The more that is written and said about the problem, the more apparent it becomes that much of our knowledge about addiction is incomplete or outdated. It is now beyond dispute, however, that orthodox measures for controlling deviant behavior have been singularly unsuccessful in solving this problem.

The undiminished persistence of addiction and its related ills has led ultimately to reappraisal of past policy and a greater interest in new approaches. Public acceptance of addiction as an illness rather than as a crime has provided strong impetus and respect for proponents of new policies. As a result, the outpouring of ideas and programs for reform has, not surprisingly, been substantial. As one author recently concluded, "In the effort to deal with narcotics in the United States, if there is anything more plentiful than problems, it is suggested solutions. Many are based on emotion without reference to known facts. Others are based on incomplete facts, without a trace of humanity." [1]

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Of the programs presently under serious consideration, proposals for compulsory civil commitment of addicts for treatment and cure are receiving the most favorable response. At the same time, though not necessarily complementary to the commitment movement, the policy of harsh punishment for narcotic drug offenses, as typified by legislatively created high mandatory minimum sentences coupled with strict proscriptions on suspension of sentence, probation and parole, is becoming the object of increasing dissatisfaction. This report will deal with those two aspects of the narcotics problem in the United States and will recommend the position which seems appropriate with respect to them.

CIVIL COMMITMENT

Civil commitment of narcotic addicts [2] generally is understood to mean compulsory confinement in a special narcotics treatment facility, followed ultimately by outpatient treatment under intensive parole-type supervision. The accepted treatment regimen consists of withdrawing the addict entirely from his physical dependence upon narcotics and providing therapy and training to overcome his psychological dependence upon drugs. Commitment is for an indeterminate period not to exceed a prescribed maximum period of years. For purposes of this analysis commitment of narcotic addicts has been divided into the following four categories:

(*a*) Involuntary commitment of "noncriminal addicts"—*i.e.,* addicts who are neither charged with crime nor under sentence for conviction of crime;

(*b*) Involuntary commitment of "criminal addicts"—*i.e.,* addicts who have been charged with crime but who have not pleaded guilty or been convicted, and addicts who have either pleaded guilty to or have been convicted of a crime;

(*c*) Commitment upon request or consent of "criminal addicts";

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*This report was submitted to the Commission in August 1966.

[1] Eldridge, "Narcotics and the Law," 104 (1962) [hereinafter cited as Eldridge].

[2] Unless otherwise indicated, the term "addicts" refers to persons who, without a physician's prescription, habitually use opium or any of its derivatives, cocaine, or any synthetic drugs or other substances generally classified as narcotic drugs because of their similarity to opiates. Not included in this term are persons who use only hallucinogens or dangerous drugs, such as marihuana, LSD, peyote, barbiturates, or amphetamines. However, persons who are principally addicted to narcotic drugs but also use hallucinogens or dangerous drugs are included.

(*d*) Commitment upon request of "noncriminal addicts."

Although many questions of law and public policy are common to some or all of these categories, the most significant issues arise under the first two categories.

INVOLUNTARY CIVIL COMMITMENT OF NONCRIMINAL ADDICTS

Programs for involuntary civil commitment of narcotic addicts are not entirely of recent vintage. A number of States have at various times in the past enacted statutes authorizing commitment of noncriminal addicts for treatment in much the same fashion as commitment of the mentally ill.[3] These laws, however, have been used very infrequently.[4] For one thing, some of them require that commitment be on the petition of one of the addict's relatives,[5] few of whom have been willing to take such action.[6] Furthermore, few States have provided any sort of specialized facilities or personnel for treatment of addicts. Under most of these programs, commitment would be to a regular mental health facility where addicts typically are placed in isolation, given little or no treatment, and discharged with alacrity by hospital administrators who have found them difficult to handle in an ordinary institutional setting and a disturbing influence generally. While a few States, the Federal Government, and some municipalities have provided special facilities for the treatment of addicts upon their request, the concept of involuntary civil commitment remained largely dormant until recently.

Although in 1961 California adopted the first comprehensive program for involuntary civil commitment of criminal as well as noncriminal addicts,[7] the serious impetus to present movements to enact Federal [8] and State commitment programs can be traced to the 1962 Supreme Court decision in *Robinson* v. *California*.[9] Proponents of such programs have found major support in a portion of the Court's opinion which in effect says that although addiction itself cannot be punished as a crime, a State can require addicts to undergo treatment for this illness.[10] They rely too upon the long-established and largely unquestioned practice of involuntary commitment of the mentally ill [11] and the practice of isolating and quarantining persons affected with serious, highly contagious diseases.[12]

Putting aside momentarily the question of the precise reach of the *Robinson* decision, it should be apparent upon close analysis that involuntary commitment of the mentally ill differs significantly from and is not convincing precedent for involuntary commitment of noncriminal narcotic addicts. The usual requirement for mental health commitments is a judicial or administrative finding that the individual to be committed is dangerous to the person of others or himself, or to property [13]—although in some jurisdictions [14] (notably the District of Columbia) [15] commitment is limited to cases of danger to persons alone.[16] The standard of danger warranting commitment varies somewhat, but the prevailing view holds that it must be a reasonably probable and immediate danger, not merely a possible or conjectural one.[17] In other words, commitment must be based upon a specific finding that there is a substantial likelihood the person to be committed will, rather than may, commit dangerous acts.

An alternative standard which has been adopted by many jurisdictions permits a mentally ill person to be committed on a finding that he is in need of care and treatment which he refuses to undergo.[18] Implicit in this criterion is the existence and availability of a method of treatment which offers something more than a vague possibility of curing the illness for which the person is to be committed.[19] The existence of a known method of treatment for narcotic addiction would appear to have been implicit in the Supreme Court's statement in *Robinson*.

Under proposed and existing programs for involuntary commitment of noncriminal addicts a person may be committed merely upon proof that he is addicted to narcotic drugs.[20] There is no requirement that the court find specifically that the addict is dangerous to others or himself, or to property.[21] Nor does it appear reasonable to conclude from a finding of addiction alone that a particular addict represents a probable or likely danger. At the very least, it is now clear that the popular image of addicts as a group being a danger to the person of others is fallacious: in fact, the opposite would appear to be the case. "[T]he number of arrests of addicts for violent offenses against the person, such as rape and aggravated assault, was only a fraction of the proportion of such arrests among the population at large." [22]

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[3] See, e.g., Ala. Code, title 22, §§ 249–250 (1958); Calif. Welf. & Inst. Code, §§ 3100–3109; Del. Code Ann., title 16, § 4714 (1953); D.C. Code, §§ 24–601 to 24–615 (1961); Fla. Stat. Ann., § 394.22 (1960); Ga. Code Ann., title 42, § 818 (1957); Iowa Code Ann., §§ 224.1–224.5 (Supp. 1965); La. Rev. Stat., title 28, § 53 (Supp. 1965); Md. Code Ann., art. 16, § 43 (Supp. 1965); Mass. Ann. Law, ch. 111A, §§ 3—5 (Supp. 1965); Mich. Stat. Ann., § 14.808 (1956); Minn. Stat. Ann., § 254.09 (1959); Mo. Stat. Ann., §§ 202.360–202.390 (1962); Nev. Rev. Stat., §§ 433.250–433.280; N.J. Stat. Ann., §§ 30: 4–177.14, 30: 4–177.16 (1964); N. Mex. Stat. Ann., §§ 54–7–35 to 54–7–36 (1962); N.Y. Ment. Hyg. Law, § 206; N.C. Gen. Stat., §§ 35–30 to 35–32 (1950); Pa. Stat. Ann., title 50, §§ 2061–2069 (1954); R.I. Gen. Law, §§ 21–28–57 to 21–28–58 (1956); Tenn. Code Ann., §§ 33–918 to 33–920 (1955); Vt. Stat. Ann., §§ 18.2901–18.2902 (1959); Wash. Rev. Code, §§ 69.32.070, 72.48.030; Wis. Stat. Ann., § 51.09 (Supp. 1966).

[4] "In 1952 drug addicts constituted less than 1 per cent of all first admissions to state mental institutions and one-tenth of 1 per cent of the resident hospital population." Lindman and McIntyre, "The Mentally Disabled and the Law" 19 (1961) [hereinafter cited as Lindman & McIntyre].

[5] See, e.g., Mich. Stat. Ann., § 14.808 (1956) (petition of guardian, next of kin, or some other suitable person designated by the probate court); N.Y. Ment. Hyg. Law, § 206(2) (repealed, N.Y. Sess. Laws 1966, ch. 192, § 8) (petition of relative or person with whom addict resides); N.C. Gen. Stat., § 35–30 (1950) (spouse, parent, child, or other relative); Pa. Stat. Ann., title 50, § 2063 (1954) (petition of parents or relatives).

[6] See Governor Nelson A. Rockefeller, "War on Crime and Narcotics Addiction: A Campaign for Human Renewal," Special Message to the New York Legislature 4–5 (Feb. 23, 1966).

[7] Calif. Welf. and Inst. Code, §§ 3000–3305.

[8] Although there are no proposals presently before Congress to establish a program for involuntary commitment of noncriminal addicts, there should no longer be serious question concerning the authority of the Federal Government to adopt such a program as a necessary and proper means to assure the effectiveness of its regulation of narcotic drugs under the tax and commerce powers and pursuant to international commitments. See, e.g., *Houston, E. & W. Tex. Ry* v. *United States* (Shreveport Rate Case), 234 U.S. 342 (1914); *Heart of Atlanta Motel Inc.* v. *United States*, 379 U.S. 241 (1964); *Katzenbach* v. *McClung*, 379 U.S. 294 (1964); cf. Aronowitz, "Legal Aspects of Arms Control Verification in the United States" 16–18 (1965). But see President's Advisory Commission on Narcotic and Drug Abuse, Final Report 70 (1963):

> It appears * * * that the federal government has only a limited power of civil commitment. Where the narcotic * * * abuser has committed no federal crime, there is not [*sic*] statute conferring federal jurisdiction over his person and therefore no federal right to commit him. Only where he is charged with the commission of a federal crime is there federal jurisdiction over his person.

[9] 370 U.S. 660 (1962).

[10] Id. at 664–65.

[11] See, e.g., testimony of Thomas C. Lynch, attorney general of California, before the Special Narcotics Subcommittee of the Senate Judiciary Committee, 89th Cong., 2d sess., mimeo at 4 (Jan. 25, 1966).

[12] See, e.g., Miller, "Federal Narcotic Controls and the Addict Society," 1966 N.D.A.A. 8, 10 (Jan.–Feb.); Levine, "Narcotic Addiction as Viewed by a Federal Narcotic Agent," 28 Fed. Prob. 30, 32 (Dec. 1964); Kuh, "A Prosecutor's Thoughts Concerning Addiction," 52 J. Crim. L., C. & P.S. 321, 323–26 (1961).

[13] See Lindman & McIntyre 17–18, 44–48.

[14] Id. at 17.

[15] D.C. Code, § 21–545(b) (Supp. V, 1966):

> If the court or jury finds that the person is mentally ill and, because of that illness, is likely to injure himself or other persons if allowed to remain at liberty, the court may order his hospitalization * * *.

See id., §§ 21–521, 21–522, 21–544. See also Note, *District of Columbia Hospitalization of the Mentally Ill Act*, 65 Colum. L. Rev. 1062, 1068 (1965).

[16] "Society's interest in preserving property is not great enough to justify confining someone solely on a prediction that he is likely to damage property." Note, "Civil Commitment of the Mentally Ill: Theories and Procedures," 79 Harv. L. Rev. 1288, 1291 (1966). Cf. Weihofen, "The Definition of Mental Illness," 21 Ohio St. L. J. 1, 9 (1960).

[17] Ex parte *Harcourt*, 27 Cal. App. 642, 645, 150 Pac. 1001, 1003 (1915); see *In the Matter of Dallas O. Williams*, 157 F. Supp. 871, 876 (D.C.C.), aff'd, 252 F. 2d 629 (D.C. Cir. 1958); *In re Heukelekian*, 24 N.J. Super. 407, 409, 94 A. 2d 501, 502 (1953); cf. *Warner* v. *State*, 297 N.Y. 395, 401, 79 N.E. 2d 459, 463 (1948); *Crawford* v. *Brown*, 321 Ill. 305, 313, 151 N.E. 911, 914–15 (1926); *Emmerich* v. *Thorley*, 35 App. Div. 452, 455–56, 54 N.Y.S. 791, 793 (1st Dept. 1898); *In re J. W.*, 44 N.J. Super. 216, 221–22, 130 A. 2d 64, 69 (1957). See also Comment, 56 Yale L. J. 1185 (1947):

> The right to restrain an insane person against his will without legal process existed at common law whenever confinement was necessary to prevent personal or property damage * * *. Reflecting the initial common law doctrine, commitment in the early statutes was limited to the dangerous insane.

[18] See Lindman & McIntyre, 17, 44–48; Note, "District of Columbia Hospitalization of the Mentally Ill Act," 65 Colum. L. Rev. 1062, 1068 (1965).

[19] See Birnbaum, "The Right to Treatment," 46 A.B.A.J. 499, 503 (1960); Kittrie, "Compulsory Mental Treatment and the Requirements of Due Process," 21 Ohio St. L. J. 28, 37 (1960); cf. *Commonwealth* v. *Page*, 339 Mass. 313, 317–18, 159 N.E. 2d 82, 85 (1959). See also D.C. Code, § 21–562 (Supp. V, 1966).

[20] See, e.g., Calif. Welf. and Inst. Code, § 3106; N.Y. Ment. Hyg. Law, § 206; Mass. Ann. Law, ch. 111A, § 4 (Supp. 1965). In California a person may also be committed if he is "in imminent danger of addiction." Calif. Welf. and Inst. Code, § 3106.

Moreover, despite the large number of addicts involved in nonviolent, property crimes, the wide disparities in estimates of the number of addicts nationally or in particular communities renders any sort of conclusion regarding the probability of danger to property from addicts as a group unreliable.[23] "The existing information on drug abuse is pitifully inadequate. No one knows exactly how many drug abusers there really are in the United States. The number of narcotic addicts alone is estimated to be between 45,000 and 100,000." [24] Assertions about the involvement of all or most addicts in property crimes are based on comparisons of addicts arrested for such crimes with questionable estimates of the total number of addicts. Furthermore, since estimates of the addict population are drawn almost exclusively from arrest records of law enforcement agencies,[25] any conclusions based upon such data regarding the probable propensity of a particular addict to commit property crimes is clearly unreliable. To use such a conclusion as the sole basis to deprive an individual of his liberty is a serious departure from recognized standards and is unreasonable. Even well-founded generalizations about the potential dangerousness of particular groups or classes have not previously been recognized as sufficient to commit an individual member of any such group. As one court, in a related context, said:

> Many persons who are released to society upon completing the service of sentences in criminal cases are * * * surely potential menaces to society * * *. Yet the courts have no legal basis for ordering their continued confinement on mere apprehension of future unlawful acts, and must wait until another crime against society is committed or they are found insane in proper mental health proceedings * * *.[26]

The alternative standard for committing a mentally ill person, *i.e.,* that the person refusees to undergo needed treatment, has a surface appearance of fitting the narcotic addict. Addiction is now recognized by most physicians and others as a form of mental illness, in the broadest sense of that term; and the evidence is clear that very few addicts will voluntarily undergo currently accepted methods of treatment which require total abstinence from addictive drugs.[27] Despite these similarities, however, there is no evidence that the method of treatment which would be imposed upon the addict if he were committed offers any reasonable hope of curing his addiction. At present, proponents of involuntary commitment can offer virtually no empirical data to support the claim that institutionalization in a drug-free environment followed by intensive aftercare supervision offer even a fair chance of cure for the average narcotic addict. Assertions to the contrary appear to be based mainly on faith, a strong desire to find a cure, and a willingness to accept that which has the ring of logic but has not as yet been supported in fact.

The only comprehensive involuntary commitment program for addicts in full-scale operation at the present time is the California narcotic addict rehabilitation program.[28] This program, which started in September 1961, provides for involuntary commitment of criminal [29] and noncriminal addicts [30] to a special treatment facility designed and staffed exclusively for the care and treatment of addicts.[31] Involuntary commitment is for a minimum period of 42 months and a possible maximum of 10 years.[32] An addict can be discharged from the program only after he completes at least 6 months of institutional care followed by 36 consecutive months of abstinence from drugs while on supervised outpatient status.[33] Between September 15, 1961, and December 31, 1965, more than 5,300 addicts were committed to the program.[34] Of this number, approximately 1,200 had been committed prior to January 1, 1963 making them potentially eligible for release by June 30, 1966, after a minimum of 42 months in the program.[35] Of these 1,200 addicts, 56, or less than 5 percent, had been discharged by May 31, 1966, upon completion of 3 drug-free years on outpatient status.[36] It should be noted, however, that the 5-percent discharge figure does not take into account approximately 10 percent of the total number of those committed who are returned to the courts as undesirable,[37] as well as a fairly large number who were discharged by the courts during the first 2 years of the program because of errors in commitment procedures.[38] But, even after making allowance for these factors, the experience so far with more than 3,200 addicts who have been placed on supervised outpatient status is not encouraging. After lengthy institutionalization,[39] only one out of five addicts released to outpatient status has remained drug-free in the community for 2 years or more, and one out of three for up to 1 year.[40] Although these figures may be an improvement over earlier treatment programs which did not provide compulsory outpatient supervision,[41] there is little evidence at present to support assertions that involuntary civil commitment of addicts offers a reasonable prospect of cure—certainly nothing approaching the results currently being attained for mental health commitments.[42]

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[21] Compare Va. Code, § 37-154 (1953) (repealed, Va. Acts 1964, ch. 640):

> Any person who through use of * * * habit forming drugs, has become dangerous to the public or himself and unable to care for himself or his property or family, and for either of these reasons has become a burden on the public, shall * * * if * * * found * * * to be in the condition abovementioned * * * be committed to a State hospital for the mentally ill * * *.

[22] Finestone, "Narcotics and Criminality," 22 Law and Contemp. Prob. 69, 71 (1957).

[23] California Department of Justice, "Drug Arrests and Dispositions in California" 2 (1964):

> The extent to which drug offenders are also involved in other kinds of crime *has never been documented* but is believed by many authorities to be quite extensive. [Emphasis added.]

[24] President's Advisory Commission on Narcotic and Drug Abuse, Final Report 4 (1963).

[25] The statement has been made repeatedly that it is almost impossible for a narcotics addict to avoid coming to the attention of the authorities within 2 years after he becomes addicted, and that the total number of addicts known to the Federal Bureau of Narcotics is a complete picture of the addict population. See, e.g., Winick, 14 Bull. Narcotics 1, 2 (No. 1, 1962); Eldridge 75. The Bureau's files, which assertedly contain a running census of the addict population in the United States, is compiled from the Bureau's own activities in the enforcement field and from reports of local and State law enforcement agencies throughout the United States. See President's Advisory Commission on Narcotic and Drug Abuse, Final Report 28–29 (1963); Eldridge 68–70. If, as is often done, the Bureau's statement of the total number of addicts is used as the base against which is compared the number of addicts who are known by officials to be involved in crime, then it follows that almost all narcotic addicts are engaged in crime. This conclusion, however, is fallacious. For one thing, the Bureau's census is a notoriously inaccurate guide to total addict population. Apparently, "there are thousands of addicts and narcotic users who never come in contact with the law; and, says a White House report, 'one can only speculate concerning the similarities between these persons and those known to the police.' " Narcotic Drug Study Commission of the New Jersey Legislature, Interim Report at VIII (1964). See Cantor, "The criminal law and the narcotics problem," 51 J. Crim. L., C. & P. S. 512, 520 (1961). Moreover, there are tremendous disparaties between the Bureau's estimates and those of State and local officials of the number of addicts in particular communities. At the end of 1964 the narcotic files of the California Department of Justice "indicated that California has *three times* the addicts attributed to it by the Federal Bureau of Narcotics. In 1964, California law enforcement had detected 18,335 addicts while the FBN reported only 6,624 for our State." Testimony of Thomas C. Lynch, attorney general of California, before the Special Narcotics Subcommittee of the Senate Judiciary Committee, 89th Cong., 2d sess., mimeo at 13 (Jan. 25, 1966). [Emphasis in original.] See Eldridge 75–79.

[26] *In the matter of Dallas O. Williams*, 157 F. Supp. 871, 876 (D.D.C.), aff'd, 252 F. 2d 629 (D.C. Cir. 1958).

[27] See, e.g., Winick, "Narcotics Addiction and Its Treatment," 22 Law and Contemp. Prob. 9, 29–30 (1957).

[28] Calif. Welf. and Inst. Code, §§ 3000–3305.

[29] Id., §§ 3050–3054.

[30] Id., §§ 3100–3111.

[31] See Wood, "Preventive Law: The California Rehabilitation Center," 2 San Diego L. Rev. 54 (1965).

[32] Calif. Welf. and Inst. Code, §§ 3151, 3200, 3201.

[33] Id., §§ 3151, 3200.

[34] California Narcotics Rehabilitation Advisory Council, Second Annual Report 3, 9 (1966).

[35] Letter from Roland W. Wood, superintendent of the California rehabilitation program, June 24, 1966.

[36] Telephone interview with Roland W. Wood, June 12, 1966.

[37] Ibid.

The foregoing is not meant to condemn the efforts being made in California, nor is it meant to rule out the possibility that at some future date a more acceptable rate of success will be demonstrated. It does, however, raise the question of whether at this time it is fair or reasonable for the Federal Government or the States to enact or support programs which will result in individuals who are not under a charge or conviction of crime being deprived of their liberty when there is no assurance that at least a fair number of them will be cured of their addiction. If specific proof does not exist that a particular individual represents an imminent or likely danger to others or himself, or that there is a fair chance he can be cured within some reasonable period of time, then commitment has all the connotations of an invidious method of achieving incarceration for a sickness which in and of itself cannot be punished criminally.

The facade of benevolence generally associated with civil commitment programs does not avoid the danger that such programs can be used as a means of circumventing ordinary criminal safeguards in order to remove "undesirables" from society and to keep them in custody for long or indefinite periods during which there is little expectation of providing efficacious treatment. There is some evidence which indicates that achieving these ends was intended when the New York Legislature recently adopted a compulsory commitment program for noncriminal addicts.[43] A newspaper account of the attitudes of New York legislators is revealing:

> Most of the debate on the bill concerned a controversial provision under which any addict could be committed against his will for a treatment program lasting up to 3 years.
>
> * * * * *
>
> Speaker after speaker voiced frustration at the failure of medical science to find a cure for narcotics addiction. Max Turshen, Democrat of Brooklyn, expressed the feelings of colleagues on both sides of the aisle when he said:
>
> "We haven't got the medical answer. So we've got to do the next best thing. We've got to keep these people off the streets."
>
> Albert Blumenthal, one of a group of Reform Democrats who sought to delete the compulsory commitment section of the Rockefeller bill, said:
>
> "Perhaps we should tell the public that we're faced with a threat as great as bubonic plague—and until we find a cure we're going to set up a concentration camp in every community." [44]

Under these circumstances, it is pertinent to ask whether there can be any justification "for broadening the commitment policy to permit compulsory commitment for curative purposes when it is known that no treatment would be forthcoming?" [45] It does not seem unfair to conclude that as long as there is no evidence to show that existing methods for treating addiction hold out a reasonable prospect of cure, civil commitment is but a euphemism for imprisonment.[46]

Advocates of involuntary commitment also rely heavily for support upon the established public health practice of isolation and quarantine of persons infected with contagious diseases. According to this view, narcotics addiction is a highly infectious disease which is spread by addicts; thus justifying the community in isolating them to protect itself from further infection.[47] The attempt to analogize to practices involving highly contagious and often fatal diseases—such as tuberculosis, smallpox, typhoid fever—is unconvincing.[48] There are marked dissimilarities between narcotic addiction and communicable diseases from which the public traditionally has protected itself by compulsory isolation of the diseased person.[49] For example, there is no evidence that narcotic addiction can be spread by occasional or intermittent contact; or that all or even a fair percentage of addicts are responsible for spreading the disease; or that any sizable number of persons is at all susceptible; or that there is any reasonable danger of fatalities resulting from addiction. In some of these respects, narcotic addiction may represent less serious public health problems than alcoholism or smoking.[50]

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[38] Between 1962 and 1964 there were 926 persons released for this reason. California Narcotics Rehabilitation Advisory Council, Second Annual Report 3 (1966). It is not known how many of these addicts were committed prior to Jan. 1, 1963.

[39] The median period of initial institutionalization in the California Rehabilitation Center before transfer to outpatients status is 15 months for men and 11 months for women. Id. at 10.

[40] Id. at 2.

[41] A study of 1,900 residents of New York City who were discharged between 1952 and 1955 from the Federal narcotics treatment center at Lexington, Ky., indicates that 90 percent of them became readdicted; most within 6 months of their discharge. U.S. Department of Health, Education, and Welfare, "Narcotic Drug Addiction," Mental Health Monograph No. 2 at 11 (1963). See also Chien, "Juvenile Narcotics Use," 22 Law and Contemp. Prob. 54, 55 (1957).

[42] See Ulett, Hardwicke, Masterman, and Cravens, "A Study of the Relative Effectiveness of Intensive Psychiatric Treatment Hospitals and Missouri's State Mental Hospitals" (mimeo. 1964), which reports that mental patients at intensive treatment centers and at large mental hospitals in Missouri have the following chances in 100 of being returned to the community as sufficiently recovered to function in society and not be readmitted to the hospital for at least 3 years:

Intensive Treatment Centers

after 1 month, 48 out of 100
after 3 months, 72 out of 100
after 6 months, 80 out of 100
after 12 months, 81 out of 100

Large Mental Hospitals

after 1 month, 16 out of 100
after 3 months, 36 out of 100
after 6 months, 48 out of 100
after 12 months, 55 out of 100

Between 80 and 85 percent of mentally ill persons admitted for the first time to institutions in North Carolina and to Veterans Administration hospitals are released within 90 days as having sufficiently readjusted to society. See statements of Dr. Eugene A. Hargrove, Commissioner of Mental Health, North Carolina, and Dr. John J. Blasko, Assistant Director of Psychiatry and Neurology Services, Veterans Administration, reprinted in Hearings before the Subcommittee on Constitutional Rights of the Senate Judiciary Committee, "Constitutional Rights of the Mentally Ill, Part I: Civil Aspects," 87th Cong., 1st sess. 180 and 206 respectively (1961). See also Malzberg, "Rates of Discharge and Rates of Mortality Among First Admissions to the New York Civil State Hospitals," 37 Mental Hygiene 619 (1953).

[43] N.Y. Sess. Laws 1966, ch. 192; N.Y. Ment. Hyg. Law, §§ 200–214.

[44] New York Times, Mar. 31, 1966, p. 1, col. 3. See Governor Nelson A. Rockefeller, "War on Crime and Narcotics Addiction: A Campaign for Human Renewal," Special Message to the N.Y. Legislature 3 (Feb. 23, 1966):

> Society has failed to face the challenge of narcotics addiction. For years dedicated men and women have devoted their time, energy, and resources, through both public and private agencies to deal with the problem. They have made encouraging inroads. *But such efforts are necessarily small in relation to the size of the problem and experimental in nature.* [Emphasis added.]

Compare California Special Study Commission on Narcotics, Final Report 4 (1961); Note, "California Narcotics Rehabilitations: De Facto Prison for Addicts?," 1 San Diego L. Rev. 58 (1964).

[45] Kittrie, "Compulsory Mental Treatment and the Requirements of Due Process," 21 Ohio St. L. J. 28, 37 (1960).

[46] See report of opposition by the American Civil Liberties Union to the recently adopted New York program, New York Times, Feb. 27, 1966, p. 1, col. 1; compare President's Advisory Commission on Narcotic and Drug Abuse, Final Report 67 (1963); Model Penal Code, § 6.12, comment (Tent. Draft No. 2, 1954).

[47] See, e.g., Ausubel, "The Case for Compulsory Closed Ward Treatment of Narcotic Addicts," 31 F.R.D. 58, 69 (1963); note 10 supra.

[48] See generally Grad, Public Health Law Manual 46–52 (1965).

Moreover, "contagion," as customarily used in this context, is conceived of as being nonvolitional on the part of those in danger of becoming infected. For example, a person drinking water containing typhoid bacilla has not knowingly or voluntarily ingested the bacilla: he has chosen merely to quench his thirst; he has not chosen to risk infecting himself with a potentially fatal disease.

Addiction to narcotics is not involitional in this sense, except for the relatively few cases of medical addicts and infants born to addicted mothers. From the outset, the risk of addiction inherent in the use of narcotics is known to the user; and although he may not take narcotics with the intention of becoming addicted, he knowingly accepts the risk when he voluntarily uses the drug. Those who choose not to partake of narcotics cannot be addicted despite repeated and close contact with an established addict. Thus, implicit in the claim that addiction is contagious in a way that warrants the drastic public health measure of isolation is the assumption that contact with an addict deprives a person of his volition and renders him, because of such contact, as susceptible to addiction as, say, to tuberculosis. But if this were so, then the addict population would be increasing at a far greater rate than is presently believed to be the case.[51]

Without detracting from the seriousness of addiction as a disease, the oft-heard assertions that the addict is indispensible to, or is primarily responsible for, new addiction are neither self-evident,[52] nor sufficient to satisfy established standards and practices warranting compulsory isolation for the protection of the community.

In addition to questions of fairness and reasonableness of proposals for the involuntary commitment of noncriminal addicts, such programs can lead to a variety of official abuses where commitment proceedings can be instituted on the petition of a public official or police officer. Since proof of addiction would be a requisite for commitment, there will be the problem of gaining evidence of such in each case. The accepted means of establishing the fact of addiction for these purposes is by the testimony or written report of physicians[53] who have examined and tested the alleged addict at some medical facility where he was placed by some official, such as a health or peace officer,[54] or by a court upon the petition of "anyone" including a public official.[55] In order to take a person into custody for the purpose of examination, there must at least be reasonable grounds for suspecting that he is addicted.[56] Past experience with programs for commitment of addicts on petition of their relatives or persons with whom they reside indicates that there will be very few instances where information sufficient to take the person into custody for examination will be acquired from relatives or friends. The requisite evidence, then, will have to be obtained either by observation of objective signs of addiction or from voluntary admissions by the suspected addict himself. The latter would be unlikely;[57] the former would present both administrative and legal difficulties. Constant surveillance of a suspected addict over a long enough period would in many cases probably result in observing sufficient objective manifestations of addiction to satisfy the requirements for placing him in a hospital for medical observation. But the manpower and time required to do this on any meaningful scale would be prohibitive.

The alternatives would be either to stop suspected addicts for purposes of examining them for signs of addiction, such as needle punctures, or to take suspected addicts into custody on bogus charges, such as vagrancy, disorderly conduct, or loitering, and examine them at the time of booking. The former would be an abuse of the person's fourth amendment rights unless, as would be unlikely in most cases, the officer who stopped the person had reasonable grounds to suspect that he was addicted.[58] The alternative of taking a person into custody under a charge such as vagrancy, is an abusive practice of many local law enforcement agencies[59] that should not be fostered by creating a need to obtain sufficient information to support detention of a suspected addict for purposes of medical observation, the results of which are to be used to support a petition of commitment.

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[49] See Amer. Public Health Assoc., Control of Communicable Diseases in Man 13, 15 (8th ed. 1955):

> *Communicable disease.*—An illness due to an infectious agent or its toxic products which is transmitted directly or indirectly to a well person from an infected person or animal, or through the agency of an intermediate animal host, vector, or the inanimate environment.
>
> *Isolation.*—The separation for the period of communicability of infected persons from other persons, in such places and under such conditions as will prevent the direct or indirect conveyance of the infectious agent from infected persons to other persons who are susceptible or who may spread the agent to others.

[50] See, e.g.. U.S. Public Health Service, Report of the Surgeon General's Advisory Committee, Smoking and Health (1964); Lindman and McIntyre 18–19; cf. Hughes, "United States Narcotic Laws," [1964] Crim. L. Rev. 520, 526.

[51] In fact, if the statistics of the Bureau of Narcotics are accepted, the number of addicts in the United States has declined during the past 50 years from more than 1 million to about 55,000. See, e.g., Eldridge 7, 77; Bureau of Narcotics, Traffic in Opium and Other Dangerous Drugs—Year Ended Dec. 31, 1964 at 19 (1965). The Bureau's Chief Counsel has estimated that during this period the ratio of addicts to general population has declined from one in every 400 to one in every 3,500. Miller, "Federal Narcotic Controls and the Addict Society," 1966 N.D.A.A. 8, 9 (Jan.–Feb.).

[52] See Ausubel, "The Case for Compulsory Closed Ward Treatment of Narcotic Addicts," 31 F.R.D. 58, 62 (1963):

> In the causation of drug addiction the only essential elements are an addiction-prone personality and the availability of narcotics, licit or otherwise. If these two considerations exist there will always be drug addicts * * *.

[53] N.Y. Ment. Hyg. Law, § 206(3); Calif. Welf. and Inst. Code, §§ 3102, 3104; Mass. Ann. Law, ch. 111A § 4 (Supp. 1965).

[54] Calif. Welf. and Inst. Code, § 3100.6.

[55] N.Y. Ment. Hyg. Law, § 206(2)(a).

[56] See *Schmerber* v. *California*, 86 S. Ct. 1826, 1835–36 (1966), sustaining a State's right to extract blood for testing from a driver suspected of being intoxicated, provided that initially there was probable cause to believe he was intoxicated—i.e., if there was sufficient cause to arrest him for being intoxicated, he could then be compelled to submit to the test; cf. Remington, "The Law Relating to 'On the Street' Detention, Questioning and Frisking Suspected Persons," 51 J. of Crim. L., C. & P.S. 386, 392–93 (1960). Compare D.C. Code, § 21–521 (Supp. V, 1966) requiring "reason to believe that a person is mentally ill and, because of that illness, is likely to injure himself or others" in order to take a person into custody; Mass. Ann. Law, ch. 111A, § 4, authorizing involuntary examination of an addict only if there exists "reasonable grounds to suspect him of being addicted." See also Annot., 92 A.L.R. 2d 570 (1963). Compare *In the Matter of Dallas O. Williams*, 157 F. Supp. 871, 876 (D.D.C.), aff'd, 252 F. 2d 629 (D.C. Cir. 1958):

> The mere fact that commitment without due process is temporary and for the purpose of psychiatric examination renders it no less unlawfull. As broad as the general equity jurisdiction of the judicial system is, it cannot be said to override specific * * * constitutional guarantees of personal liberty.

[57] See *Miranda* v. *Arizona*, 86 S. Ct. 1602 (1966).

[58] See Remington, "The Law Relating to 'On the Street' Detention, Questioning and Frisking of Suspected Persons," 51 J. of Crim. L., C. & P.S. 386, 392, nn. 38–40 (1960).

Apparently, no court has yet passed on the question of whether the exclusionary rule applied in criminal prosecutions applies in civil commitment proceedings. See *Mapp* v. *Ohio*, 367 U.S. 643 (1961); *Elkins* v. *United States*, 364 U.S. 206 (1960); *Weeks* v. *United States*, 232 U.S. 383 (1914). Although some courts have relied upon the "civil" nature of commitment proceedings to conclude that certain constitutional guarantees need not be afforded (see, e.g., *In re De La O*, 59 Calif. 2d 128, 150–51, 378 P. 2d 793, 807–08, cert. denied, 374 U.S. 856 (1965)), the loss of personal liberty which is the object of compulsory commitment is compelling reason for strict application of constitutional safeguards. Cf. *One 1958 Plymouth Sedan* v. *Pennsylvania*, 380 U.S. 693 (1965) (exclusionary rule applicable to forfeiture proceedings). See also *In the Matter of Dallas O. Williams*, 157 F. Supp. 871, 876 (D.D.C.), aff'd, 252 F. 2d 629 (D.C. Cir. 1958).

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> Cases * * * indicate that, where suspicious circumstances cause an arrest for vagrancy, something more than status is involved. The charge may be a mere cloak for an arrest that officers have been ordered to make, an arrest for some other offense, as a means of validating what would otherwise be an illegal search.

Foote, "Vagrancy-Type Law and Its Administration," 104 U. Pa. L., Rev. 603, 628–29 (1956). There is evidence that vagrancy convictions without evidence of vagrancy have been used as a means of institutionalizing persons suspected of being mentally ill. Id. at 633–34. Compare La Fave, "Arrest: The Decision to Take a Suspect into Custody" 437–89 (1965); *White* v. *United States*, 271 F. 2d 829, 831 (D.C. Cir. 1959); *Taglavore* v. *United States*, 291 F. 2d 262, 265–66 (9th Cir. 1961). See also *Hutcherson* v. *United States*, 345 F. 2d 964, 971 (D.C. Cir. 1965) (Bazelon, J. dissenting); Parker, Daily Training Bulletin of the Los Angeles Police Department 56 (1958).

I conclude, therefore, that at this time the Federal Government should neither adopt a program for involuntary commitment of noncriminal addicts, nor should it urge the States to adopt such programs or support them financially or otherwise.

INVOLUNTARY COMMITMENT OF CRIMINAL ADDICTS

For purposes of analysis, the question of involuntary civil commitment of criminal addicts requires separate consideration of addicts who have been charged with crime and have entered pleas of not guilty and are awaiting trial, and those who have entered pleas of guilty or have been convicted of a criminal charge.

Addicts awaiting trial

Individuals who have been taken into custody on a legitimate charge of crime could properly be subjected to a search and at least a cursory physical examination at the time of arrest and while awaiting a preliminary hearing or arraignment before a judge, commissioner, or magistrate. If civil commitment of addicts were authorized, evidence of addiction discovered during such initial examination (such as needle punctures or signs of withdrawal) could be used for the purpose of placing the arrested person under medical observation to determine whether in fact he was addicted and subject to commitment.[60] Therefore, a serious objection to involuntary commitment of noncriminal addicts would be largely obviated in the case of an addict properly charged with crime. But the other misgivings which are inherent in programs for involuntary commitment of addicts are present here as well. The fact that a narcotic addict is properly in custody awaiting trial on a charge he denies, does not make it reasonable or fair to commit him to an institution under civil process when there is no finding that he represents an immediate danger to others or himself, or to institutionalize him for treatment without his voluntary consent when there is no reasonable assurance of cure. Therefore, an addict awaiting trial on a criminal charge that he denies should not be subject to involuntary civil commitment solely because of his addiction.[61]

Addicts convicted of crime

Commitment to a narcotic treatment facility of an addict who has been convicted of crime or has entered a plea of guilty presents entirely different issues. Assuming that the court has sentenced the addict to a period of incarceration, it would not be necessarily unreasonable or unfair to confine him in a narcotics treatment center instead of an ordinary penal institution. Commitment under a program of this sort, however, would be unfair if it adversely affected the length of a prisoner's confinement or the conditions of his release. Of particular concern here is the maximum period for which he could be confined in a treatment center, the conditions of his release on parole, the maximum period he could be kept in aftercare status, and the sanctions which could be imposed for breach of conditions of aftercare.

Involuntary commitment of a convicted addict to a treatment program should be for a total period not to exceed the term for which he was sentenced on the criminal charge. The maximum period he could be kept under treatment should include his time in actual confinement as well as in aftercare status. Thus, if an addict were convicted of a charge carrying a maximum sentence of 5 years and he was sentenced by the court to serve 24 months, the total time he could be kept in custody in an institution and in aftercare should not exceed 24 months.

Under the California program an addict who has been convicted of or pleaded guilty to a criminal offense can, in lieu of imprisonment, be committed to the narcotics treatment program for an indeterminate period of not less than 42 months and up to 10 years.[62] No distinction for purpose of length of commitment is made between felonies and misdemeanors or other lesser offenses; nor is any attempt made in the law to have the maximum permissible period of commitment reflect the sentence which the addict could or would have received for his offense. Thus, for example, a misdemeanant who could be jailed for a maximum of a year or less, can be institutionalized for as long as 10 years. The California Supreme Court has sustained this practice as a reasonable and permissible exercise of the State's power to regulate illicit traffic in narcotic drugs.[63]

New York has modified this somewhat by authorizing a maximum period of commitment of 3 years for an addict convicted of a misdemeanor or the offense of prostitution,[64] and 5 years for an addict convicted of a felony.[65] Under proposed Federal legislation sponsored by the administration and recently approved by the House of Representatives, a criminal addict could be involuntarily committed for an indeterminate period not to exceed the maximum sentence that could otherwise have been imposed, but in no event to exceed 10 years.[66]

A basic objection to all of these schemes is that the period of time many, if not all, addicts committed to these programs will remain under restraint (either institutional or aftercare) is longer than if they had been sentenced in the normal fashion to a term of imprisonment for the offense they committed. As long as evidence is lacking to support claims of the existence of successful treatment methods, there is no justification for subjecting addicted criminals to longer periods of institutionalization and parole-type supervision than nonaddicts who have committed the same offenses.[67] This inequity can be avoided by sentencing criminal addicts in the usual fashion for the offense they have committed and having the decision on the type of institutionalization made afterwards. The maximum period of treatment, then, would be for the sentence given for the offense.[68]

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[60] This assumes that after arrest the person was brought before a judge or commissioner for a hearing without unnecessary delay. Fed. R. Crim. P. 5(a); *McNabb* v. *United States*, 318 U.S. 332 (1943); *Mallory* v. *United States*, 354 U.S. 449 (1957).

[61] None of the existing state programs nor any of the proposed Federal commitment programs specifically authorize involuntary commitment of an addict awaiting trial on a charge to which he has pleaded not guilty.

[62] Calif. Welf. and Inst. Code, §§ 3151, 3200, 3201. Compare Mass. Ann. Law, ch. 111A, § 7 (Supp. 1965) (maximum of 3 years).

[63] *In re De La O*, 59 Calif. 2d 128, 378 P. 2d 793, cert. denied, 374 U.S. 856 (1963).

[64] N.Y. Ment. Hyg. Law, § 208(4)(a).

[65] Id., § 208(4)(b).

[66] Title II, H.R. 9167, 89th Cong., 2d sess. (passed by the House June 1, 1966) (hereinafter cited as "H.R. 9167"). Compare title III, S. 2191, 89th Cong., 1st sess. (1965), which would authorize the Federal courts to commit addicts convicted of crime to a treatment program for a maximum of 18 months of institutional care, followed by 3 years of supervised aftercare.

[67] Any relationship between a 10-year maximum period of commitment and the requirements of the treatment authorities is brought into question by the statement of the House Judiciary Committee that the 10-year maximum "provides a lengthy period of sentence for those recalcitrant offenders who do not respond to treatment." H.R. Rept. No. 1486, 89th Cong., 2d sess. 12 (1966).

Ordinarily it might seem appropriate to permit the sentencing judge to decide whether an addict should be confined in a prison or sent to a treatment facility; this could, however, have an adverse affect on the addict's sentence. There is the possibility that if judges make the decision to commit to a treatment center instead of to prison they will impose longer terms than they would ordinarily for the same crimes in the belief that the longer term will benefit the defendant by giving the treatment authorities a longer time to work with him. Judges might also view confinement in such a facility as less onerous than confinement in a penitentiary. The possibility of addicts who are committed for treatment receiving longer sentences than would normally be meted out should and can be avoided by placing the decision as to commitment to a treatment facility or prison with the correctional authorities who receive the defendant for classification after sentencing.[69] By keeping uncertain at the time of sentencing the defendant's ultimate type of confinement, the courts can be expected generally to sentence in their normal fashion without taking into account extraneous factors, such as the time needed to treat a particular defendant's addiction. This method will also place the decision with those who, by virtue of their expertise and their opportunity to appraise the prisoner during the initial period of classification, are generally in the best position to evaluate the chances of treatment succeeding with particular addicts. The discretion of the correctional authorities to place an addict prisoner in a treatment center rather than a prison should be largely unrestricted. Only those addicts who are convicted of the most serious crimes and, perhaps, recidivists whose crimes are unrelated to their addiction should be excluded from a treatment program.[70]

Addicts committed for treatment should be accorded the usual benefits of time off for good behavior. They should be entitled to early release if their conduct has met ordinary requirements for early release from a penal institution.[71] They should not be prejudiced by failure to respond to treatment (unless accompanied by intentionally disruptive or incorrigible behavior), or by the need of the treatment authorities for additional time to attempt to effect a cure. Similarly, eligibility for parole should be the same as for regular prisoners, particularly the time for initial eligibility and for periodic review by the parole authorities.[72]

In addition to being accorded the rights of ordinary prisoners to early release and parole, addicts committed to treatment should be eligible at any time for release from the treatment center on aftercare status upon the recommendation of the treatment authorities. Aftercare status would be similar to parole, but under more intensive supervision. Besides the ordinary conditions imposed on parolees, addicts could be required, among other things, to live in special residences and to submit to periodic and surprise testing and therapy.[73]

The maximum period for which an addict could be kept in aftercare status would be the unserved portion of his original sentence. Breach of any condition of his aftercare status would, as in the case of regular parole, be grounds for summary revocation and return to either the treatment center or an ordinary prison to serve out the balance of the original sentence.[74] In the event aftercare status is revoked, the addict should be accorded review by the parole authorities of the order of revocation [75] and, if it is confirmed and he is returned to confinement, the time spent in aftercare status prior to revocation would not be counted toward the time remaining to be served.[76] The decision whether to return the addict to the treatment facility or to a regular prison should be made, with the advice of the treatment officials, by either the parole board or the correctional authorities who made the original decision on classification. If the addict is returned for further treatment, he should remain eligible for release on aftercare status at any time that the treatment authorities conclude he is ready for such again.[77]

Finally, addicts who satisfactorily complete a program of treatment by abstaining entirely from the use of narcotics for some prescribed period while on aftercare status should have their convictions expunged.[78] Addicts whose original sentences expire before they can complete the requisite drug-free period for expungement of their conviction, should be permitted to remain in the aftercare program on a voluntary basis, under the ordinary conditions of testing and therapy, with the right to expungement of their convictions upon successful completion of the prescribed period of abstinence.[79] Those who voluntarily stay in the program after the expiration of their sentences should be subject only to loss of this privilege in the event they return to the use of narcotics or otherwise violate conditions of aftercare before the expiration of the minimum prescribed period.

VOLUNTARY COMMITMENT OF CRIMINAL ADDICTS

For purposes of analysis, voluntary commitment of criminal addicts falls into two groups: those who have either pleaded guilty to or have been convicted of a criminal charge and are awaiting sentence, or have been sentenced to imprisonment; [80] and those against whom a criminal charge is pending which has not been disposed of by either conviction or plea of guilty.

Addicts in the former group should not be accorded a right to elect voluntary commitment to a treatment center in lieu of prison. If the court imposes a sentence of imprisonment this group will, in the regular course of classification by the prison authorities, be considered for assignment to a treatment center rather than a prison.[81] There are no obvious advantages, administratively or in terms of cure, in allowing a convicted addict who is awaiting sentence or has been sentenced to a jail term even a limited right at this stage of the proceeding to exercise a choice as to type of commitment.

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[68] 42 U.S.C., § 259 (1964) requires the "authority vested with the power to designate the place of confinement of a prisoner" to place all addicted prisoners, except those who are incorrigible or unsuitable for treatment, in hospitals specially equipped to treat narcotic addicts. The period of confinement is for the sentence imposed by the court; and the addict is entitled to the usual benefits of early release for good conduct as well as parole. Cf. § 7, S. 2114 and § 8, H.R. 9051, 89th Cong., 1st sess. (1965), which would authorize Federal judges after they have pronounced sentence upon any narcotic addict to order the Attorney General to confine such persons in treatment facilities. Cf. 42 U.S.C., § 259(e) (1964), which permits Federal judges, in cases where sentence may be suspended, to place addicts on probation on the condition that they submit to treatment at Public Health Service treatment facilities until they are discharged as cured.

[69] See 18 U.S.C., § 4082 (1964).

[70] New York excludes defendants convicted of crimes for which the permissible sentences are death or life imprisonment. N.Y. Ment. Hyg. Law, § 208. Under the administration bill, a convicted defendant would be ineligible to be committed for treatment if his offense, inter alia, was sale of narcotics, unless the sale was for the sole purpose of enabling him to obtain narcotics for his own addiction; voluntary manslaughter; murder; rape; mayhem; kidnapping; robbery; burglary; housebreaking; extortion accompanied by threats of violence; assault with a dangerous weapon; assault with intent to commit any offense punishable by imprisonment for more than 1 year; or if he had been convicted of a felony on two or more occasions. Title II, H.R. 9167; title II, S. 2152, 89th Cong., 1st sess. (1965). See discussion, pp. 20–21 and notes 87 to 90 infra.

[71] See 18 U.S.C., §§ 4161–66 (1964).

[72] See 18 U.S.C., §§ 4201–07 (1964).

[73] See, e.g., Calif. Welf. and Inst. Code, § 3152; title I, § 102(b), S. 2152, 89th Cong., 1st sess. (1965).

[74] See 18 U.S.C., §§ 4205, 4207 (1964).

[75] See 18 U.S.C., § 4207 (1964).

[76] See 18 U.S.C., § 4205 (1964).

[77] Revocation of outpatient status and return to the treatment facility is the normal expectation in the California program and is not viewed as failure. See statement of Roland W. Wood, superintendent of the California Rehabilitation Center, before the Subcommittee to Investigate Juvenile Delinquency of the Senate Judiciary Committee, 89th Cong., 2d sess., mimeo. at 14–15 (January 1966).

[78] California, for example, requires three consecutive drug-free years in outpatient status. Calif. Welf. and Inst. Code, § 3200.

[79] Cf. § 304, S. 2191, 89th Cong., 1st sess. (1965).

[80] Addicts who are convicted or plead guilty and are not sentenced to imprisonment, as well as those who receive suspended sentences without probationary supervision, should be accorded the same privilege of voluntary commitment as noncriminal addicts. See pp. 23–24 infra.

There are, however, no serious objections to permitting an addict who is under a criminal charge which has not been disposed of by plea or conviction to volunteer for commitment in lieu of immediate prosecution and in the expectation that the charge will be dismissed if he successfully completes treatment.

The principal matters of concern in a program of this type are: the maximum period the addict can be held in the program; the length of time after arraignment on the criminal charge that he will have to exercise this option; and, related to these points, the need to avoid making the program so attractive as to coerce defendants, who would otherwise in good faith contest the criminal charges, to forego their defenses.[82]

The New York program and the proposals currently pending in Congress to establish this type of commitment program prescribe a maximum period of 3 years for which the addict can be kept under treatment—both institutional and aftercare.[83] It is difficult to take issue with the 3-year period, since sufficient data is not presently available to indicate whether this period is unnecessarily long or short. A 3-year period may, however, discourage persons who are charged with crimes for which the average sentence runs less than 3 years from volunteering for commitment. It would appear wiser to establish a more flexible method of setting the maximum term of commitment. For example, the term could be for some fraction, perhaps one-quarter or one-half, of the maximum sentence which could have been imposed upon conviction of the crime charged; or where there are multiple charges the same fraction of the maximum sentence which could have been imposed for the charge carrying the highest sentence. By selecting an appropriate formula, this method could be made to reflect in rough fashion the overall sentencing experience in the Federal courts for all but the most serious crimes. This would provide at least some correlation between the prison term the addict might expect to receive if convicted and the maximum period for which he will be committing himself.

A defendant should be permitted to exercise the option to request commitment at any time before his case is assigned to a judge for trial. This will afford the addict sufficient time to consult with counsel about the merits of his defenses and to make and have decided any pretrial motions which might dispose of the criminal charges in his favor.[84] By requiring a defendant to make his request for commitment within a few days after his arraignment, as under proposed Federal law,[85] pressures might be unfairly exerted upon him to forego an honest and valid defense. Moreover, by giving defendants and their counsel adequate time to study the case and to reflect upon the relative risks of defending, there will be less inducement for law enforcement agencies and prosecutors to press for indictments on questionable charges in the hope that defendants will be forced by the pressure of time to volunteer for commitment. By permitting the defendant to make his request for commitment at any time before his case is assigned to a judge for trial, he will have ample time to review his defense and to make his pretrial motions, but he will not be able to disrupt the court's or the prosecutor's trial schedules.

Defendants who are eligible for this program should be entitled to release on bail without prejudicing their right to apply for commitment within the specified period.[86] With few exceptions, all defendants whose crimes are causally related to their addiction should be eligible for commitment in lieu of prosecution. The exceptions should be limited to defendants charged with the most serious offenses (perhaps only those carrying maximum terms of life imprisonment or death) and to recidivists whose criminal activities are not principally related to their addiction. The proposed legislation currently before Congress is unduly restrictive in this respect and could be expected to eliminate a large number of addicts whose criminal behavior is the result of their addiction [87]—the very people a treatment program purportedly is meant to reach. The New York and California programs are somewhat less restrictive than the administration sponsored bills, but are also overly restrictive.[88] If it is indeed true that addicts, in order to support their habits, frequently act as small-time pushers and are responsible as well for a disproportionate number of property crimes (such as burglary and theft), then it is difficult to fathom the intent behind provisions which exclude from eligibility for commitment a defendant who has a prior felony conviction, or is charged with burglary, housebreaking or robbery, or any offense involving sale of narcotics without taking into account the circumstances of the sale. These restrictions do not seem justified in view of the espoused rehabilatative intent of commitment legislation.[89] Moreover, since the ultimate decision on whether to commit in lieu of proceeding on the criminal charges would be left to the courts, it would seem wiser to permit a greater latitude so that decisions can be based upon individual cases.[90]

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[81] See pp. 13–18 supra.

[82] Strong objections to any type of commitment program which holds the criminal charge in abeyance have come from various sources. Critics of this sort of program are concerned that addicts who do not respond to treatment will be returned to the courts to stand trial on the abeyant criminal charges long after the commission of the alleged offenses. In such cases, both the prosecution and the defense may be seriously prejudiced by the inevitable loss of evidence. See, e.g., H. Rep. 1486, 89th Cong., 2d sess. 51–52 (1966) (minority report). This objection apparently is the reason California did not adopt a preconviction commitment program. See testimony of Thomas C. Lynch, California attorney general, before a Special Narcotics Subcommittee of Senate Judiciary Committee, 89th Cong., 2d sess., mimeo. at 10 (Jan. 25, 1966).

[83] N.Y. Ment. Hyg. Law, § 210; title I, H.R. 9167; title I, S. 2152, 89th Cong., 1st sess. (1965), which would establish the maximum period of commitment at 36 months, but would permit the courts to continue the addict in probationary aftercare for 2 additional years.

[84] Under the New York legislation no time period is prescribed in which the defendant must make his application for commitment in lieu of prosecution.

[85] See title I, H.R. 9167, which allows the defendant a maximum of 5 days after being advised by the court of his right to request commitment to make his election. The bill leaves it to the court's discretion when to advise a defendant of this option. Under § 2, S. 2113, and § 1, H.R. 9051, 89th Cong., 1st sess. (1965), an addict would be permitted 5 days after his first appearance on the criminal charge to make this election.

[86] An objection raised to permitting a defendant who has been released on bail after arraignment to apply for commitment is the possibility that if he were not an addict at the time of his initial arraignment he might intentionally become addicted while on bail in order to avoid prosecution on the criminal charges. See H. Rept. 1486, 89th Cong., 2d sess. 54 (1966) (minority report). This concern seems farfetched. Under the bill enacted by the House a defendant has the usual right to bail until he makes the election and is committed by the court to the Surgeon General for initial examination. Title I, H.R. 9167.

[87] Under the bill sponsored by the administration, a person would be ineligible for commitment if he were charged, inter alia, with unlawfully selling a narcotic drug; voluntary manslaughter; murder; rape; mayhem; kidnapping; robbery; burglary; housebreaking; extortion accompanied by threats of violence; assault with a dangerous weapon; assault with intent to commit any offense punishable by imprisonment for more than 1 year; or if he had been convicted of a felony on two or more occasions. Title I, H.R. 9167.

An earlier version of the administration proposal contained the same exclusions, except that a person charged with selling a narcotic drug would be eligible if the court determined that such sale was for the primary purpose of enabling the defendant to obtain narcotics required for his own addiction. Title I, S. 2152, 89th Cong., 1st sess. (1965). A similar provision was inserted in H.R. 9167 by the House Judiciary Committee, but apparently was deleted on the floor. See H. Rept. 1486, 89th Cong., 2d sess., 2, 5, 6 (1966). It is noteworthy that under title II of H.R. 9167, an addict who has been convicted of selling narcotics is eligible for involuntary commitment if the court determines that the sale was for the sole purpose of enabling the offender to obtain narcotics for his own addiction. See H. Rept. 1486 supra at 12.

Under a bill sponsored by Senators Javits and Kennedy, voluntary commitment would be available exclusively to defendants charged with violating Federal penal laws relating to narcotics, but would exclude such defendants if the charge involved, inter alia, sale to another and the defendant knew that the purchaser intended to resell the narcotics, or if the defendant had been previously convicted of a felony on two or more prior occasions. § 2, S. 2113, 89th Cong., 1st sess. (1965).

A bill sponsored by Representative Celler would similarly apply only to persons charged with Federal offenses involving narcotics but would make ineligible for commitment only such persons who are charged with sale of narcotics with knowledge that the purchaser intends to resell. § 1, H.R. 9051, 89th Cong., 1st sess. (1965). See testimony of Representative Emanuel Celler, Hearings before Subcommittee No. 2 of the House Judiciary Committee, 89th Cong., 1st and 2d sess., ser. 10 at 55 (1965); testimony of California Attorney General Thomas C. Lynch before a Subcommittee of the Senate Judiciary Committee, 89th Cong., 2d sess., mimeo. at 9–10 (Jan. 25, 1966). Compare Mass. Ann. Law, ch. 111A, § 7 (Supp. 1965), which excludes a defendant from commitment:

> If the amount of drugs alleged in the charges pending against * * * [him] is so substantially greater than would be necessary to supply * * * [his] own narcotic habit that he appears to be primarily involved in illegally trafficking in drugs for profit rather than seeking money solely to help support his own narcotic habit * * *.

A defendant requesting commitment would be required to undergo a short period of hospitalization for testing and observation to verify the existence and extent of his addiction.[91] At the conclusion of the testing he would be returned to his previous status, either bail or detention, and the medical observers would report to the court regarding the defendant's addiction and the prognosis for cure. The court should hold a hearing if it deems it necessary or if requested by the defendant, who should be represented by counsel if he so desires; and the defendant should be given a full opportunity to contest findings of the medical observers which are adverse to his application.[92] If the court decides to commit the defendant it would compute the maximum period for which he could be retained in treatment and transfer him to the custody of the appropriate treatment officials.

The report and findings of the medical observers and all statements made by the defendant in his petition for commitment, during his medical observation and during any hearings held by the court on his application should be privileged except for proceedings related to his commitment.[93]

An addict who is committed to a treatment center under this program could be retained in the institution for all or any part of the term of his commitment. The decision regarding the period to be spent in institutional care and in aftercare treatment should be in the discretion of the treatment officials.[94] When an addict is released on aftercare status he would be subject to parole-type supervision; he could be required to live in special residences and to undergo periodic testing and therapy.[95] Breach of conditions of his aftercare status would be grounds for returning him to the treatment center.[96]

At the end of the term for which the addict has been committed, the treatment authority would return the addict to the custody of the committing court with a report of his progress, his conduct during commitment, and an evaluation of his ability to remain free of addiction. The original charge should be dismissed if the addict was cooperative during treatment and succeeded in abstaining from narcotics while on aftercare status.[97] The addict should be given a copy of the report submitted to the court and should be accorded a hearing to contest it if unfavorable.[98]

If during treatment the addict becomes uncooperative or incorrigible, or cannot be treated medically, the treatment authority would have discretion to advise the court and request that his commitment be canceled and he be returned to the custody of the court for disposition of the pending criminal charges.[99] The addict should be granted a hearing upon request to contest the treatment authority's application.[100] If the court cancels his commitment, or does not dismiss the original charge after completion of the period of commitment, the pending criminal charge should then be disposed of in the normal manner. If the defendant is convicted of the original charge, the time he spent in actual confinement in a treatment facility should be credited against any prison sentence imposed by the court.[101]

VOLUNTARY COMMITMENT OF NONCRIMINAL ADDICTS

The problems encountered in other phases of civil commitment do not exist with respect to voluntary commitment of addicts who are not charged with crime or otherwise under direct supervision or restriction pursuant to the sentence of a court. The Federal Government and some States have for many years provided special facilities for treatment of addicts upon their request.

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[88] N.Y. Ment. Hyg. Law, § 210(2):

> A defendant against whom an indictment information or complaint is pending is eligible for civil certification if:
>
> (a) he has not previously been convicted of a felony;
>
> (b) he has not previously been certified to the care and custody of the commission;
>
> (c) the charge against him is not one which is punishable by sentence of death or life imprisonment; and
>
> (d) the charge against him is a felony and the district attorney consents to such certification, or the charge against him a misdemeanor or the offense of prostitution.

Calif. Welf. and Inst. Code, § 3052 excludes, inter alia:

> * * * persons convicted of, or who have previously been convicted of murder, assault with intent to commit murder, kidnapping, robbery, burglary in the first degree, mayhem * * *.

[89] See, e.g., H. Rept. 1486, 89th Cong., 2d sess. 7–10 (1966).

[90] See testimony of Representative Emanuel Celler, hearings before subcommittee No. 2 of the House Judiciary Committee, 89th Cong., 1st sess., ser. 10, at 55 (1965):

> All these exclusionary devices are based on the fear that somehow civil commitment will be used as a means of escaping punishment for some other crime. Each individual case must be scrutinized to determine whether civil commitment will be efficacious. I submit that it should not be the Congress who, at long distance, makes such determinations. In the absence of the facts of individual cases, these decisions can only be arbitrary. The judge is on the scene and has the facts necessary for an informed judgment.

[91] Under title I, H.R. 9167, a defendant requesting commitment is confined for examination for a period up to 60 days. Under the New York program there is no specific provision for committing a defendant for an examination, N.Y. Ment. Hyg. Law, § 210; although a noncriminal addict against whom involuntary commitment proceedings have been commenced may be ordered to submit to an examination for which no maximum period of time is prescribed. N.Y. Ment. Hyg. Law, § 206(2)(c)(3). Similarly, California does not provide for commitment for examination of a convicted defendant suspected of being addicted, Calif. Welfare and Inst. Code, § 3051; but does provide for commitment for examination of a noncriminal addict and requires such examination to be completed in no more than 72 hours. See also Mass. Ann. Law, ch. 111A, § 4 (Supp. 1965), which requires an examination ordered by the court to be completed within 10 days of the court's order.

[92] The administration bill makes no provision for a hearing on the defendant's application for commitment, nor does it afford him an opportunity to contest the medical findings. The Celler bill as well as the Javits-Kennedy bill would afford the defendant a hearing on this issue. See § 1, H.R. 9051, and § 3, S. 2113, 89th Cong., 1st sess. (1965).

[93] See, e.g., title I, H.R. 9167.

[94] Ibid.

[95] Ibid.

[96] Ibid.

[97] Under the administration bill, the abeyant criminal charges are dismissed "if the Surgeon General certifies to the court that the individual has successfully completed the treatment program." There is no specification of what constitutes successful completion of treatment. Ibid. The Celler and the Javits-Kennedy bills use the criteria of effective removal from habitual use of narcotic drugs and successful completion of aftercare treatment. § 1, H.R. 9051, and §§ 4, 5, S. 2113, 89th Cong., 1st sess. (1965).

[98] None of the pending bills provide for a hearing in the event an unsatisfactory report is rendered to the court by the treatment authority. It seems inappropriate not to provide the addict with an opportunity to contest findings which will determine whether, after spending an extended period of time in treatment, he is to be discharged from custody or will be required to stand trial on the original criminal charges; particularly where the standard is as imprecise as "successfully completed the treatment program." See H. Rept. 1486, 89th Cong., 2d sess. 51–52 (1966) (minority report):

> There can be no question that the offer of the election—and the determination of a defendant's eligibility—would represent serious steps in the criminal proceedings * * *. Down one path lies jeopardy; prosecution, conviction for a crime, and a possible 5-year minimum sentence in prison. Down the other lies non-penal rehabilitation: hospital treatment, work release (after-care) and eventual dismissal of the criminal charge without trial. It is apparent to us that the defendant will be entitled to a hearing and to reasons for the court's actions.

[99] See title I, H.R. 9167; § 4, S. 2113 and § 1, H.R. 9051, 89th Cong., 1st sess. (1965).

[100] See note 85 supra.

[101] See title I, H.R. 9167. Under § 6, S. 2113 and § 1, H.R. 9051, 89th Cong., 1st sess. (1965), the defendant would receive credit for the time spent "in the custody" of the treatment authorities—presumably, this includes time in aftercare as well as in an institution.

Although programs of this type have been singularly unsuccessful in effecting cures, they have been the primary source of valuable information about the characteristics of addicts and addiction. Clearly, adequate facilities and treatment programs should continue to be made available by the Federal Government and the States to noncriminal addicts who voluntarily request treatment.

A factor frequently assigned for the extremely low rate of cure under existing voluntary programs is the short period of time that most addicts remain under treatment. Many addicts who become unable to supply themselves with sufficient drugs to satisfy their steadily increasing physical needs will commit themselves to a treatment facility and stay for the short period it takes to be withdrawn from physical dependence, thereby reducing temporarily the amount of narcotics they will need to satisfy their addiction. This can be accomplished in a matter of weeks, after which the addict, who under present law cannot be kept against his will, departs from the facility without having received any meaningful treatment.[102] This difficulty could be partially obviated by making voluntary commitment available only to addicts who consent to stay in a treatment facility for some minimum period—perhaps 6 months.[103] Release prior to 6 months' confinement would be permitted only upon consent of the treatment officials. Imposition of this condition might deter some addicts from requesting treatment, but at least those who do commit themselves will be with the program long enough to receive the start of whatever treatment is available and, perhaps, to be induced to stay on beyond the maximum enforceable period.[104]

SENTENCING FOR NARCOTIC DRUG OFFENSES

During the past decade the Federal Government and the States have been dramatically increasing the punishment for narcotic offenses; particularly sale of narcotics and possession with intent to sell. The device which has been used most frequently is to set a high mandatory minimum sentence and to prohibit suspension of sentence, probation, or parole for anyone convicted of these crimes.[105] In most States, however, the crime of use, as well as possession of narcotics or possession without intent to sell, have not been made the subject of harsh mandatory minimum provisions; nor have they been the occasion for denying courts their usual powers to suspend imposition or execution of sentence and to place defendants on probation.[106]

There now exists a considerable body of evidence to support the conclusion that most judges and correctional authorities, as well as many, if not most, prosecutors do not favor the high mandatory minimum provisions; particularly when accompanied by restrictions on the power of the courts to suspend and place on probation. Empirical studies conducted by the American Bar Foundation in jurisdictions where provisions of this type exist reveal that defendants are seldom convicted of crimes carrying heavy mandatory minimum penalties.[107] Prosecutors have found that charging crimes carrying mandatory minimum sentences results in few if any guilty pleas and makes plea bargaining virtually impossible. Moreover, when mandatory minimum offenses are charged, they are almost invariably reduced to a lesser charge under pressure from the courts except in cases of "flagrant" offenders.[108] As a result, it is customary in some jurisdictions for prosecutors either to charge the lesser offense initially, or to reduce the charge at the time of arraignment.[109]

Legislatures enacted mandatory minimum penalties and denied courts and correctional authorities discretion as to suspension, probation, and parole on the assumption that both groups were overly lenient in their treatment of narcotic offenders and that the imposition of harsh penalties would deter trafficking by making the risk disproportionately great.[110] There is little evidence to support claims of irresponsible leniency by the judiciary or parole authorities prior to the adoption of these provisions [111] and no evidence, other than unsubstantiated assertions by law enforcement officials, that mandatory minimum sentences have significantly reduced the illicit narcotics traffic.[112] In States where normal sentencing procedures have been retained but the maximum permissible sentences for narcotics offenses have been increased, these crimes are charged, juries convict, and judges impose heavy sentences in appropriate cases.[113] But in States where high minimums are made mandatory and judges are denied their ordinary and traditional discretion to make sentencing distinctions between particular offenses and defendants, the system has largely failed.[114]

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[102] See, e.g., H. Rept. 1486, 89th Cong., 2d sess. 9 (1966). See also Winick, "Narcotics Addiction and Its Treatment," 22 Law and Contemp. Prob. 9 (1957).

[103] Six months of abstinence is believed by many to be the time required for the addict to regain physiological normality. See, e.g., Winick, "Narcotics Addiction and Its Treatment," 22 Law and Contemp. Prob. 9, 24 (1957). This estimate apparently influenced the California Legislature to require a minimum of 6 months of institutionalization. See Calif. Welf. and Inst. Code, § 3151. See also testimony of Thomas C. Lynch, attorney general of California, before a subcommittee of the Senate Judiciary Committee, 89th Cong., 2d sess., mimeo. at 10 (Jan. 25, 1966). But see Eldridge 115, who concludes from the experience at Lexington that "the last vestiges of physiological changes * * * have disappeared" within 4½ months and "in many patients it will be much earlier."

A bill sponsored by Senators McClellan and Lausche would establish a voluntary commitment program for noncriminal addicts that would be instituted by petition to a Federal court. If the petitioner is found to be addicted he would be committed under court order for a period of 6 months unless released sooner by the Surgeon General or the court because his addiction had been cured or his continued confinement would no longer be necessary or desirable. Title II, S. 2191, 89th Cong., 1st sess. (1965).

[104] Sec. 207, S. 2191, 89th Cong., 1st sess. (1965).

[105] For example, Federal law prescribes a mandatory minimum sentence of 5 years for a first narcotics offender and 10 years for a second narcotics offender who: (*a*) illegally imports narcotic drugs or marihuana into the United States, or, inter alia, receives, conceals, buys, or sells any illegally imported narcotic drug or marihuana (21 U.S.C., §§ 174, 176a (1964)); (*b*) sells, transfers, etc., narcotic drugs or marihuana without receiving a written order from the buyer on an official Treasury Department order form (26 U.S.C., §§ 4705(a), 1742(a), 7237(a) (1964)).

A mandatory minimum of 10 years is prescribed for any person 18 years or older who sells, transfers, etc., any narcotic drug or marihuana to a person under 18 years (26 U.S.C., § 7237(b) (1964)).

A manadatory minimum of 2 years for a first narcotics offender is prescribed for: (*a*) purchasing, selling, dispensing, or distributing narcotic drugs not in the original package bearing tax-paid stamps (26 U.S.C., §§ 4704(a) (1964)); (*b*) acquiring, transporting, or concealing marihuana for which Federal transfer taxes have not been paid (26 U.S.C., §§ 4744(a) (1964)).

Although the specific acts prohibited by these statutes are phrased in terms of importation, sale, transfer, etc., mere possession of illegal narcotics or marihuana is also a crime by virtue of rebuttal presumptions contained in most of these statutes making possession alone sufficient evidence to authorize conviction. Under Federal law, therefore, possession of narcotics or marihuana can result in a conviction requiring the imposition of a mandatory minimum sentence of either 2 or 5 years, depending on the statute under which the defendant is charged. See 21 U.S.C., §§ 174, 176a (1964); 26 U.S.C., §§ 4704(a), 4744(a) (1964).

An integral part of this sentencing structure is the prohibition on suspending the imposition or execution of sentence or granting probation or parole upon conviction of any of these offenses, except for first narcotics offenders convicted of crimes which carry a 2-year mandatory minimum. 26 U.S.C., § 7237(d) (1964).

[106] See Eldridge, app. B, 149-193.

[107] During 1956 and 1957 the American Bar Foundation carried out extensive field studies of almost all phases of the administration of the criminal laws in Michigan, Wisconsin, and Kansas. All three States have mandatory minimum sentences, coupled with restrictions on suspension of sentence, probation and parole, for a variety of crimes—including narcotic offenses. An analysis of the data relating to the administration of these provisions is contained in Newman, "Conviction: The Determination of Guilt or Innocence without a Trial" 42, 99, 112-14, 177-84 (1966) [hereinafter cited as Newman].

[108] In Michigan, the charge of sale of narcotics, which carries a mandatory minimum of 20 years with restrictions on suspension, probation, and parole, is invariably reduced to possession. Id. at 177-78. Similar results were found in Kansas and Wisconsin in almost every instance of crimes carrying mandatory minimums. Id. at 42.

> Both Kansas and Michigan are characterized by legislatively fixed sentencing structures. Wisconsin is not, but even in that state there are certain offenses which carry mandatory penalties. Judges and prosecutors in all three states, when confronted with mandatory penalties, typically use charge reduction as a device to obtain what they consider to be desirable sentence flexibility. Id. at 114.

[109] See id. at 114-16, 177-84.

[110] See, e.g., Subcommittee on Narcotics, House Committee on Ways and Means, 84th Cong., 2d sess., "Illicit Traffic in Narcotics, Barbiturates and Amphetamines in the United States" 13-15 (1956); cf. Anslinger and Tompkins, "The Traffic in Narcotics" 167, 295-97 (1953).

Furthermore, the claim that mandatory minimum penalties deter possession and sale of narcotics has proceeded on a false premise with respect to many persons charged with these offenses. A large number of defendants arrested for these crimes are addicts who peddle small quantities of drugs as a means of supplying their own habit.[115] The prospect of a jail term, no matter how long, apparently will not deter them from an activity which often is the only way they can secure a supply of narcotics to satisfy their own needs. In almost all such cases, these offenders lack the will power which is a requisite for harsh penalties to be an effective deterrent.[116] Moreover, harsher penalties have not only increased the risks of trafficking, but they have also increased the price and the profits of illicit narcotics. As a result, there has not been a noticeable decrease in the amount of illicit narcotics being sold in the United States [117] or, apparently, in the number of nonaddicted traffickers who find the potential profits at least equal to or greater than the risk.

There is sufficient evidence that judges will impose heavy penalties on nonaddicted sellers as well as addicts who sell primarily for profit, but they will not cooperate with a system which denies them discretion to fix the punishment to fit the individual case. There is also evidence that many prosecutors are dissatisfied with mandatory minimum provisions which unnecessarily interfere with the ordinary disposition of cases by plea at an early stage. In addition, legislative restrictions on parole for narcotic offenders results in addicts, who have served lengthy jail terms, being released into the community without the benefit of professional supervision which may be of some aid in deterring releasees from returning to narcotics.[118] Under these circumstances, it is unwise to retain mandatory minimum penalties or to restrict the traditional discretion of the courts and the correctional authorities to fashion the punishment in each individual case in a way that will afford adequate protection for the community while taking account of the deterrent and rehabilitative effect of the sentence. By providing sufficiently high maximum sentences for narcotic offenses, the threat for the nonaddicted trafficker will remain and the courts can be expected to impose appropriate sentences in such cases.

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[111] In fact, there is evidence that in some States judges have been anything but lenient with addicted offenders. The Bar Foundation field studies reveal that the judges in Detroit consider all narcotic addicts to be poor probation risks. Their general sentencing policy is to impose prison terms on addicted offenders, whether or not the conviction was for a narcotics offense. In exceptional cases they will grant probation on the condition that the addict enter a treatment facility and follow a recommended treatment program. They will also consider probation for an addict who has cooperated with the police by acting as an informer or has helped the police contact and make a case against a pusher. American Bar Foundation, "The Administration of Criminal Justice in the United States: Pilot Project Report," vol. III (1957) (cited with permission of the American Bar Foundation); Dawson, "The Sentence" (proposed publ. 1967).

The proposed Model Penal Code would authorize the court to suspend sentence and place defendants on probation in all cases except those where the sentence is death or life imprisonment. Model Penal Code, § 6.02, comment (Tent. Draft No. 2, 1954):

> This provision rests on the view that no legislative definition or classification of offenses can take account of all contingencies. However right it may be to take the gravest view of an offense in general, there will be cases comprehended in the definition where circumstances were so unusual, or the mitigation so extreme, that a suspended sentence or probation would be proper. *We see no reason to distrust the courts upon this matter or to fear that such authority will be abused.* [Emphasis added.]

[112] See Eldridge 72–74.

[113] See California Special Study Commission on Narcotics, final report, 35–37 (1961).

[114] See id. at 36–37.

> Graphic evidence as to what has happened under the strict Michigan laws to prosecutions of narcotic peddlers can be found in the statistics compiled by the Detroit Narcotic Squad since 1952. During the last 8 years, 1,005 defendants have been charged with the peddling of narcotics. Out of this number, only 30 individuals have been convicted of peddling narcotics * * *. Most of the remainder of these cases resulted in guilty pleas to lesser offenses.
>
> Two conclusions can be drawn from Michigan's experience with a 20-year minimum sentence. *Juries will convict* if given an opportunity, but few sales cases ever reach the jury because most are disposed of by guilty pleas to lesser offenses. *Judges* will not enforce 20-year mandatory punishment laws which take away their right to grant probation or suspend sentence in exceptional cases.
>
> In Ohio, where the courts are given the right to grant probation or suspend sentence, and parole is available, probation for narcotics peddlers is practically unheard of. Probation can be granted, or a sentence suspended, in exceptional cases. No pressure is exerted by the court on the prosecution to accept a lesser plea.
>
> The Commission believes that Ohio judges stand solidly behind the new, more severe punishment laws because their discretionary powers have not been tampered with. [Emphasis in original.]

Compare Newman 112; Eldridge 118–25; testimony of Representative Emanuel Celler, Hearings before Subcommittee No. 2 of the House Judiciary Committee, 89th Cong., 1st and 2d sess., ser. 10, at 56 (1965); Narcotic Drug Study Commission of the N.J. Legislature, Interim Report 103 (1963). Cf. Model Penal Code, § 6.07, comment (Tent. Draft No. 2, 1954): "The lesson of experience with habitual offender laws is * * * that maxima of life imprisonment should not be lightly authorized and that, in any case, long terms should be discretionary and not mandatory. When they are mandatory, they result in inequality of application and extensive nullification."

[115] See, e.g., California Special Study Commission on Narcotics, Final Report, 40–41 (1961).

[116] See President's Advisory Commission on Narcotic and Drug Abuse, Final Report 3 (1963).

[117] "It has been estimated by the Department of the Treasury that about one and one-half tons of heroin are smuggled annually into this country. Customs seizures average less than one hundred pounds a year. The Bureau of Narcotics in 1962 seized 164.34 pounds." Id. at 5. During 1964, the total quantity of illict narcotics seized in the United States by Federal authorities was approximately 225 pounds. Bureau of Narcotics, "Traffic in Opium and Other Dangerous Drugs—Year Ended Dec. 31, 1964" 84 (1965).

[118] See Narcotic Drug Study Commission of the New Jersey Legislature, Interim Report 105 (1963); Klonsky, "Extended Supervision for Discharged Addict-Parolees," 29 Fed. Prob. 39 (March 1965); Wood, "Preventive Law: The California Rehabilitation Center," 2 San Diego L. Rev. 54, 55 (1965). See also Eldridge 123:

> Parole and probation should be utilized in narcotics offenses as they are in other criminal offenses. Parole, particularly, can play an important part in the correctional process when dealing with narcotic addicts. It is generally accepted that addiction is largely the result of personal inadequacy, emotional instability, and social maladjustment * * *. When the possibility of parole is denied, it means that these people who particularly need supervision are returned to the environment which spawned their troubles without any assistance whatever. It is argued that addicted offenders have a high recidivism rate, and do not warrant the risk involved in releasing them on parole. If parole meant merely release, the argument might be salient; but parole is much more than a conditional release from confinement. It is a rehabilitative process which envisions assisting the offender to adjust to social responsibility.

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